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Supreme Court, U.S.
FILED

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OFFICE OF THE CLERK

No.

Supreme Court of the United States
1st Street N.E. DC 20543-Clerk Office
202-479-3011

Joseph S. Maresca- Petitioner-Pro Se

versus

Dr. Elliot L Mancall MD Respondents
Thomas Jefferson University Hospital

On Petition for a Writ of Certiorari
Appendix- BOOK II

To the Court of Appeals 3rd Circuit: 04-3103
(Rendell, Fuentes, Opinion by Garth
on 6-8-05 ;issued 6-16-05
Reconsideration Denial 12-19-05; Writ Due 3-20-06)

Joseph S. Maresca-Pro Se- PETITIONER
Of Record
Bronxville, NY 10708-0646
914-649-3817

RESPONDENTS

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BOOK II OF II

BOOK II

APPENDIX

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A131-2 Dermatologist encounter form with note "iron hand on scalp pulls upward-3 years" by Diplomate Abel MD with note to see a Rheumatologist-Dr.Abel MD noted the facial pulling in the 12-5-96 examination of Dr.Mancall MD (Defendant)

A.133 Pathology report of Dr.Dworkin MD-Surgeon findings of Crohns 12-20-91 noted in Dr.Mancall's encounter form 12-5-96

A.134 Article on Mortality Among Patients with Ankylosing Spondylitis Not Given X-ray Treatment VOL. 297 7: 572-7 9-15-77 New England Journal of Medicine cited as per Civil Rule 803.18 with attributions to other authors citing this article

APPENDIX - CONTINUED

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In the Writ of Certiorari, the Respondent utilizes some exhibit numbers in the sequence of the District Court-Trial Exhibits provided the Court in duplicate numbers 1-300. This record might be called subsequent to oral arguments.

These exhibits are contained in the writ because the Trial Court record & 3rd Cir. Appellate must be ref. in the Writ.

Description	Trial Exhibit	Supreme Court-APP.
Diplomate Deng	12	A. 39, A 40
Dr.Mancall MD Defendant	Trial Exh.43-53 ;55	A 115-128
Letter brought to Dr.Mancall exam of 12-5-96 by patient	49	A. 124, A 125
Dr.Waterman MD Rheumatologist	94, 95	A. 67-69
Dr.Abel MD Dermatologist 7-28-99 encounter	135	A.131.132
New England Jour. of Medicine on Anky. Spon. Mortality by Radford et al.	Exh. 279	A. 134

Description	Trial Exh.	Supreme Court APP.
Diplomate Felder MD Expert-Neurologist	142-5 in DC 76-9 3rd Cir. APP	A135-143
Dr.Epstein MD Defense Expert	153-5	A. 161-165
Thomas Jeff, Univ Encounter form of Dr. Mancall MD	Exh. 43 A.008 in 3rd Cir.	A. 115-116
Drs.Terraciano & Dr.Joseph DeCarlo MDs (Opth.-Iritis Findings)	Exh. 112, 114	A 129, 130
Dr.Dworkin MD Surgeon discovered Crohn's Disease 12/91	A. 117, 118	A. 133

Trial Testimony of Diplomate Felder MD-Neurologist
1-16-04 played on 5-4-04 and 5-5-04

Transcript Page- 3rd Circuit APP	Supreme Court APP
107 p. 12 ln.7	A 87
108 p. 13,14	A88, 89
112 p. 32 ln. 11	A96
118 p. 54 ln. 5-21	A 106, A 107
120 p. 63 ln. 17 onward	A 110, A111
121 p. 66 ln. 13-21	A 111, A112
133 p. 115 ln. 3-15; p116 ln.1-8	A113, A114
A. 311 p. 37 ln. 9-19	A 98

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 5, 2004

BEFORE: HONORABLE LEGROME D. DAVIS, JR.

TRIAL EXAMINATION OF JOSEPH S. MARESCA
EXCERPTS

APPEARANCES:
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COURTROOM DEPUTY: MARCELLA EL SHABAZZ

Page 160 Questioning by Mr. Goewert, Esq. for Defendant

ln. 1 Q. Anything during the visit you wanted to show me that you made up?

A. I made a diagram of what I can recall the examining room looked like. I better use this, because I don't have my copy readily available. The doctor was standing right in front of the table. I was seat on the table.

This could have been one of the problems. Dr.Mancall performed his examination. He did similar to what he did in 1991. He utilized those little hammers. I know he looked into my eyes with the physician's headgear and light. I know he also looked into my mouth. We had a discussion about what I was there for, the nature of the tension, and I described to him the tremendous pulling & discomfort. And going beyond that, I walked over to the wall and tried to press the back of my head to the wall and it would not. I know that I also

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ln. 1 A. laid on the floor and did a similar demonstration to the one that I did with the resident medical provider or assistant.

Q. Are you sure about that?

A. Yes

Q. As you sit here today in 2002, you're sure about that?

A. Yes, because it was very strange, I felt that the head was protruding.

Q. So you felt in 1996, December 5, 1996 during this visit, that you had this protrusion forward of the head that was some abnormality to you right?

A. Yes

Q. Didn't seem normal to you right?

A. Well, I detected it in doing the exercises. I was made acutely aware of it when I did the exercises. I really hadn't realized what it was until I did the karate and I started to find out what some of these limitations were.

Q. So you knew you had these limitations and that was part of what you were trying to find out is why you had these limitations back December 5 of 1996, is that right?

A. That's correct.

Q. What happened next?

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ln. 9 A. Dr.Mancall continued his exam. He questioned me, and this, I think might have been one of the problems. I don't recall that when I was on the examining table--see, my feet were over like this and I was sitting on the edge of the examining table like this (indicating).
But I don't think he actually laid me down at 180 degrees where he could have seen the protrusion of the head. I don't recall that he laid me exactly 180 degrees flat, although he might have, but I don't recall that he had me in a 180 degree flat position on the examining table where he could observe the leaning forward.

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ln. 2 Q. You showed him on the wall right?

A. Yes.

Q. And I think you said you sat on the floor and showed him on the floor, right.

A. Yes

Q. So you would have laid on the floor and showed him just like you did us?

A. Yes. But on the examining table if you're examining someone, it's a little bit more of a dynamic.

Q. What happened next?

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ln. 16 A. At some point, I brought up about the spine and he walked over maybe to the wall. And when I brought up the spine, it was almost like a holdup. He put his hands up in the air and he said: "No, no, don't touch the spine." He said it in like a whine, and I really didn't question it beyond that. I know there was a little discussion about the spinal. He may have theorized that the gravity--

Q. My question to you is very simple. What happened? Now you're giving me theories of what's in his mind.

A. No, this is really--

Q. That's really not my question.

A. --what he explained. He did some explanation to me about why that might be.

Q. Why what might be?

A. The--whatever problem I had with the spine. He felt that maybe gravity would make that worse, the forces of gravity. He said we're primates and forces of gravity might impact the spine.

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 4, 2004

BEFORE: HONORABLE LEGROME D. DAVIS, JR.

TRIAL EXCERPT-TESTIMONY OF DIPLOMATE DENG

APPEARANCES:
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COURTROOM DEPUTY: MARCELLA EL SHABAZZ
TRANSCRIBED BY: DRUMMOND TRANSCRIP
HADDON HEIGHTS, NJ. 8035
PROCEEDINGS RECORDED BY ELECTRONIC SOUND RECORDING. TRANSCRIPT BY TRANSCRIPT SERVICE.

(Excerpt of trial-testimony of Charles Deng, 5-4-2004)
THE COURT: Up here, please sir.
COURTROOM DEPUTY: Good afternoon, sir.
THE WITNESS: Good afternoon.
COURTROOM DEPUTY: Please state your full name, and spell your last name for the record.
THE WITNESS: D-e-n-g.
COURTROOM DEPUTY: Please raise your right hand. You do swear, and/or affirm, that the testimony you're about to give before this Court will be the truth, the whole truth, and nothing but the truth so help you God, or you do so affirm?
THE WITNESS: Yes, I do.
COURTROOM DEPUTY: Thank you.
CHARLES DENG, sworn.
THE COURT: You may proceed sir.
[Note: Mr.Maresca is not speaking into a microphone.]

By Mr. Maresca:
Q. Good morning, Diplomate Deng.
A. Good morning.
Q. Thank you very much for traveling the long distance here.
A. You're welcome.
Q. If you would please state your full name for the record.
A. My name is Charles Deng.
Q. Could you spell that please?
A. C-h-a-r-l-e-s last name D-e-n-g

Q. And do you have a middle name?
A. No
Q. Okay, and Charles what is your occupation?
A. Acupuncturist.
Q. Also, if you could give me an address where you live, your residence or business address?
A. Yes, now I'm working in Forrest Hills, Queens.
Q. And the address?
A. Address, 10251 Queens Boulevard, Forrest Hills, NY
Q. Mr. Deng, if you could-are you a licensed acupuncturist?
A. Yes. I'm a New York licensed acupuncturist.
Q. And what does that entail, a licensed acupuncturist? Did you have to pass an exam?
A. Yes, I had to pass the Board exam, and then I have to provide the documents of my educational background, and pass the English proficiency examination.
Q. Okay, Diplomate Deng, do you have a background in-- or have you passed courses in anatomy?
A. Yes
Q. Physiology
A. Yes.
Q. Pathology
A. Yes
Q. Have you had courses in clinical acupuncture?
A. Yes
Q. Diplomate Deng, are you a diplomate?
A. Yes
Q. What does a diplomate involve? How does this distinguish you from a regular acupuncturist?

A. Diplomate is a regular acupuncturist. Now in New York State there are two kinds of acupuncture certified, one is the certified acupuncturist which means it has the medical background, education, like a medicine doctor, dentist, and they have only to take 300 hours of training, then they got certified as an acupuncturist. That's called certified acupuncturist. It's having a certificate.
Q. And for the diplomate?
A. The acupuncturist has to be --that's a licensed acupuncturist, which means they're originally trained in the Chinese medicine system, and that's the difference.
Q. Okay, And in achieving the diplomate status, how did you achieve that, did you take a formal exam to become a diplomate?
A. Yes. I passed the National--NCCA examination--that's a NCCOM.
Q. And what distinguishes that examination from a regular accupuncturist examination?
A. That's required much more in detail, in background education, in training with the Chinese medicine system.
Q. Okay, Diplomate Deng, do you have clinical experience with conditions of the spine?
A. Yeah.
Q. Was that clinical experience derived from your training as an acupuncturist?
A. Yes.
Q. Okay. Diplomate Deng, I would like to get into when I first had an appointment, or a meeting, with you in your offices, and I would like to show you some records.

Q. continued First this-- Plaintiff's Exhibit No. 12 dated July 6. 1996. Sir , is that your record?
(P-12 office record of Diplomate Deng on Joseph Maresca dated 7-6-96 marked for identification.)
A. Yes
Q. And if you could explain to the jury, briefly, everything that you did on that date, everything you observed on that date?
A. That's the first date--the first time I see Mr.Maresca, and he came to my office--which means that's the office, the old office and old address, that's in 133 Bowery, in Chinatown. And on that day he come to me asking for help for his overweight problem and pain, stiffness of neck, shoulder which was caused by muscle spasm . And after I check up with him, I found he has a limitation of mobility of the spine, and the neck, and the lower back. It's really limited on his vertical area. He only can turn his neck on left side five degrees or so, ten degree on the right, and almost--almost cannot sit down by himself. You need to hold out the chair and then I could make it "firm". (ph.) And also by the time I check up with him on the bed, he couldn't lie down by himself, I'm holding his back to put him down. And after I check up with him, I found he has redness of face, he's sweating and hyper-liver yang condition. His chief complaint-he has a headache, and pain and stiffness on the neck and shoulder, and repeating this problem. And on that day, I give him a suggestion. I told him I couldn't help to change his condition by acupuncture,
and suggest him to see the medicine doctor to have a further checkup and find out the necessary treatment. So that's the first day. I see him. It's the first image.
Q. Diplomate Deng, from the first visit, do you recall, did you turn the patient's head to the left

A. I'm sorry, I didn't catch that.
Q. Did you turn the patient's head to the left?
A. Yeah, I check.
Q. And what did you find?
A. On the left, he's very limited, it's only like 5 degrees of turning, and then turning it back to the right side, in the (indiscernible) position, he only can turn about 10 degrees.
Q. Diplomate Deng, did you ever at any time have the patient lying flat on the examination table?
A. Yes, I did.
Q. And in the patient lying flat on the examination did you notice anything in particular?
A. His head couldn't touch on the back flatly like the other--like normal people lie down. So I have to put--double up the pillow under his neck to support his head.
Q. Is it your testimony that you had to put a double pillow under the plaintiff's head so that it would rest comfortably; is that your testimony?
A. Yes
Q. And Diplomate Deng, did that condition ever change?
A. No.

Analysis: The testimony of Diplomate Deng-Acupuncturist comports with the Brophy v. Brizuela criteria which requires obviousness of the disease process to an ordinary person. In this case, Diplomate Deng has attested to gross range of motion conditions present during 7/1996 ; such that a reasonable person could infer the need for substantial treatment and ongoing medical care. No person (after seeing the presentation of this patient) could infer that no medical treatment would be necessary.

Trial Exhibit 12

Charles Deng, NYS Lic. Acupuncturist
133-B Bowery NY, NY 10002
Tel. 212 966 8431 Date 7-6-96
Patient Information Initial Visit

Last Name: Maresca First Name: Joseph
Box 646 Bronxville NY 10708
Age: 44 years Sex: M DOB 1-14-52 Marital: S

CHIEF COMPLAINT AND HISTORY PRESENT ILLNESS
Chief Complaint: Pain and stiffness at head,neck,shoulders
What treatment has been taken for current problem:
Physical Therapy

PHYSICAL EXAM
Overweight, presently 241 lbs. Blood pressure: 135/80
2. limited spinal movement, 3-muscle spasm at neck, shoulders and upper back Respiratory: 82/min.
Temperature:Normal

Major questions and Pulse Status:There is no recent injuries to his neck, shoulders and upper back. There is no infections known to the patient. The patient's pulse is floating and strong, red tongue and yellowish coating. Fair energy and spirit.

1) upper and hyper liver yang
2) Yang min headache
3) Muscle spasm
4) Ossification of the ligament need to be confirmed in the future check-up. Patient is recommended to see the MD for further check-up.

Trial Exhibit 12- Continued

Initial treatment plan:
Lower the liver-yang by improving the kidney and liver ying energy and detoxify the liver and blood system.
Relieve the muscle spasm by acupuncture.
Balance ying-yang of kidney and liver.

WE, THE UNDERSIGNED DO AFFIRM THAT THIS PATIENT HAS BEEN ADVISED BY A LICENSED ACUPUNCTURIST TO CONSULT A PHYSICIAN REGARDING THE CONDITION OR CONDITIONS FOR WHICH SUCH PATIENT SEEKS ACUPUNCTURE TREATMENT.

PATIENT SIGNATURE: Joseph S. Maresca 7-6-96
ACUPUNCTURIST SIGNATURE: Charles Deng 7-6-96

Third Circuit Appellate Court
21400 United States Courthouse
601 Market St.
Phil. Pa. 19106-1790

Case 04-3103 Maresca v. Mancall MD et al.

Amicus Curiae Brief in Support of the Appellant-Maresca
Civil Rule 702

Submission by
Diplomate Charles Deng-Acupuncture
102-51 Queens Blvd. Forest Hills, NY
Witness: 5-4-04 Trial Appearance, 8-20-02 Deposition
11-09-02 Letter

Due Date: 11-01-04

Charles Deng Acupuncture P.C. , L. Ac.
10-13-04
Diplomate Charles Deng
102-51 Queens Blvd. Forest Hills, NY

Comments to the Appellate supporting Joseph S. Maresca under Civil Rule 702

To the Court of Appeals of the 3rd Circuit,
With the Court's permission, please admit this Amicus Curiae
statement which complements trial testimony of 5-4-04, a deposition of 8-20-02 and an 11-09-02 letter. On the first acupuncture visit of 7-6-96, the patient and now appellant Joseph S. Maresca had OBVIOUS spinal problems including the suspension of his head from the examining table while lying flat, stiffness of the head, shoulder, neck and spine, significant resistance in turning the head either left or right and an impression of ossifications. I had similar observations on at least 3 other visits during July 1996 including 7-13-96, 7-20-96 and 7-27-96. In addition, the patient could not rise from the examining table unassisted.

continued

My records also show that from August of 1996 until several years later, the patient did not get the benefit of my treatment while he was pursuing a diagnosis due to my initial suggestion to consult a medical doctor.

In the 8 years since the first visit, these rigidity issues still remain. Acupuncture complements the considerable treatment regimen for ankylosing spondylitis and the patient continues to receive treatments regularly.

Several major USA insurance carriers reimburse the acupuncture procedure.

Respectfully,
Charles Deng
Diplomate in Acupuncture

IN THE UNITED STATES DISTRICT COURT FOR
THE EASTERN DISTRICT OF PENNSYLVANIA
DEPOSITION FILED FOR TRIAL

JOSEPH S. MARESCA — CIVIL ACTION
Plaintiff
v. — NUMBER 015355
ELLIOT L.MANCALL MD
and
THOMAS JEFFERSON UNIVERSITY
HOSPITAL
Defendants

Oral deposition of Elliot L.Mancall MD was taken, pursuant to notice, held at the law offices of Marshall, Dennehy, Warner, Coleman and Goggin, 1845 Walnut St., 21st Fl. Phil. Pa. on Wed. July 24, 2002 beginning at or about 10:35 AM before Debra J. Veneziale
Court Reporter and Notary Public, there being present

APPEARANCES:
JOSEPH S. MARESCA CPA, CISA- PRO SE

MARSHALL , DENNEHY AT AL.
BY STEVEN RYAN , ESQUIRE
REPRESENTING: DEFENDANT ELLIOT L MANCALL MD

O'BRIEN AND RYAN ;BY CYNTHIA L BRENNAN, ESQ.
REPRESENTING :DEFENDANT ,
THOMAS JEFFERSON UNIVERSITY HOSPITAL

WITNESS
ELLIOT L MANCALL MD
EXAMINATION BY MARESCA

EXHIBITS Description and Page Marked

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2. Explanation of documents 5
2-1. Encounter form of 12-5-96 5
2-2 Prescription for MRI 5
2-3 Report of MRI 5
2-4 2-9-97 NOTE 5
2-5 2-15-97 NOTE 5
2-6 2-26-97 NOTE 5
2-7 Patient Summary of History 5
2-8 Report of 8-17-91 5
2-9 Blood series of 10-31-91
[5] 4 Prescription for MRI of the Brain 5
[6] Encounter form of 8-15-91 Bill of Hahneman Hosp. 5
[7] 6 Encounter form of 7-28-99
Miscellaneous medical records

Excerpts of Dr.Mancall MD's 7-24-02 Deposition filed with the District Court-E. Pa. and cited by the Expert- Diplomate Felder MD-Neurologist in his letter of
11-22-02 and in the trial examination A. 87 and A.135 to 143

Page 8

ln. 22 Q. When did you graduate medical school? A.1952
Q. Was that general medicine?

Page 9

ln.1 A. I graduated medical school with an MD; but it's general medical training
Q. Where did you complete the specialization?
ln.12 A. I specialized in neurology at a number of institutions
ln.14 Q. Where did you do your residency?
A. At the- as I say, at a number of institutions. I began at the National Hospital for Nervous Diseases in London, then the N.Y. Neurological Institute and then the Massachusetts General Hospital

Page 10

ln. 8 Q. Do you have a diplomate in neurology?
A. We do not.

Page 11 and top of Page 12

ln. 23 Q. Sir, if you would very briefly go over the commencement of the exam beginning with the head. Were you able to turn the head freely from the right to the left?

Page 12

ln. 4 A. I did not record any alteration of that. I have no specific personal recollection.
20. Q. As part of your examination did you undertake to move the patient's head from right to left?
A. I have no specific recollection of this particular exam.

ln. 4 Q. Did you at any time place your hand on the patient's neck as part of the exam?

A. I have no recollection of that.

ln. 20 Q. Did you find any rigidity or stiffness in the shoulder?

A. Not that I can recall

ln. 24 Q. Did you examine the spine at all?

ln. 1-2 A. I have no specific note to indicate that I examined the spine on that occasion and I don't recall specifically.

ln.5 Q. At any time did the patient rest flat on the table; in other words flat 180 degrees with every part of the body touching the examining table?

A. I do not recall

ln.10 Q. Do you recall the posture of the head on the examining table? When the patient was lying flat on the examining table, do you recall the posture of the head? Was the head touching the cushion of the table?

A. I cannot recall.

Page 15

ln. 1 Q. Did you touch the neck?

A. I cannot recall/

ln. 18 Q. From your visible observation, was there a deficiency in neck posture? Did the neck posture appear to be correct to you or was there a deficiency in it from looking at the patient?

A. I have no record to indicate that there was a deficiency, and I have no personal recollection of that.

Page 16

ln. 23 Q. Did you notice any spasms in the facial nerve, anything visible?

A. No, there was nothing visible that was recorded.

Page 18

ln.. 12 Q. Did you examine the pelvic area at all?

A. I have no recollection of examining that specifically.

Page 19

ln. 5 Q. Did you examine the hip extensions?

A. Yes.

Q. Did you examine the lateral rotations of the thigh?

A. I have no recollection and I have no note to that effect.

Page 20

ln.12 Q. Did you observe the patient at all either doing a sit-up or getting off the table from a flat position?

A. Not that I can recall.

Q. Did you observe any difficulty in the patient getting off the table?

A. I have no recollection and no record to that effect.

Q. Did you have to help the patient get off the table at any point?

A. I cannot remember.

Page 21

ln. 9 Q. Did you detect any bamboo leaning forward of the spine in your December 5, 1996 exam?

A. I have no recollection to that effect and I have no notes to that effect.

Page 22

ln.7 Q. So I guess you also would not have observed any kyphosis, even a mild kyphosis in that exam?

A. I have no record to that effect.

Q. Did you test the abdominal reflex at all?

A. I don't recall. I commonly do, but in this particular incident, I do not know.

Page 29

ln. 13 Q. Did he discuss at all the pulling of the facial muscles with the medical student and what the medical student's understanding of it was.

A. I commonly discuss the history with the medical student who happens to participate in the exam. I suspect I did, but I have no specific recollection.

Page 35-6

ln,23 Q. The first question is: Would there be any way of identifying the medical student who wrote the upper portion of this record?
(medical encounter form)

A. No

Page 37

ln. 15 Q. go through what you did write (on the encounter form)

A. certainly (by the witness)

Q. So that we can have a complete understanding of what you wrote.

A. All right. I wrote OE which stands for on examination, obese, blood pressure 140/80, mentation check, which means normal. Cranial nerves all normal. Fundi check, which means normal. Motor strength, bulk, tone, check, which means normal.

Deep tendon reflexes which is what PL stands for, plantars are downgoing. Cerebellar function which is spelled CBI on this note, cerebellar function normal. Sensation normal.

Diagnosis, chronic tension headaches. Rule out intraventricular tumor. Plan MRI. If okay, Fiorinal, return post MRI and then that's my signature scrawled down there.

Page 39

ln.10 Q. As an administrative question, how could the State evaluate a candidate's work experience if there name is not on the face of the form? How can a candidate prove that they have the work experience? How can you discourage three or four or five people from claiming the same work experience if the name is not on the face of the form?

MS. BRENNAN AND MR. RYAN : OBJECTIONS.

Page 42

ln. 4 Q. Did you give any specific instructions that you can recollect to one of the secretaries regarding follow-up?

A. Not that I can recall.

Page 43

ln. 1 Q. Did you review this report from the MRI of the Bronx after the MRI (brain) had been taken?

A. Yes

Q. Did you review the actual films?

A. I can only say probably. I have no specific recollection.

ln.20 Q. This is the first letter I wrote to you. It looks like Feb 9th, it's stamped Feb 13th 1997.

Did you read this memo?

A. Yes

Page 44-45

ln. 4 Q. There's a following memo on Feb. 15th , 1997 addressed to you. It looks as though it is logged Feb 24, 1997. In the first paragraph I'm conveying a number of things. There is still some tension in the forehead which worsens at night. And also I'm saying in the opening letter, the opening paragraph: Previously, we discussed that the MRI disclosed what was believed to be a normal shrinkage of the cerebellum and little else. Is that true? sir?

Q. Did you see this letter?

A. Yes

ln. 9 Q. Okay. let's move on. The next letter does not have a date stamp. It is signed by me and it is dated Feb 26th, 1997. And in the first paragraph I mention the Imitrex appears to relieve the tingling in the fingers. However, the tightening of the trigeminal nerve structures continues unabated. And at the end of the second paragraph I'm saying: At most the acupuncture translates a frozen facial mask into smaller pockets of tension. Did you read this letter?

A. Yes.

Page 46-47

ln. 16 Q. Then there was another document which brought to the Outpatient Neurology Clinic. I had given this initially to the medical student and I believe it is in the folder. At the bottom in the last-the next to the last paragraph I have in yellow: There appear to be some permanent restriction in the ability to do a sit-up and to run at maximum speed. That's mentioned in this along with other items. Did you read this memo at all?

A. Yes.

Page 49

ln. 16 Q. Do you recall filling out Exh. 5. this is a receipt for $200. of the exam of the Hahneman Hospital in 1991?

A. Yes

Q. There is a notation by you lumbosacral strain. What would you have meant by lumbosacral strain?

A. Generally speaking, I would have been referring to pain in the low back perhaps with some spasms of the muscles but I cannot recall.

Page 51

ln. 19 Q. Did you observe any stiffness in the thoracic region?

A. Well I have no-those records are not available to me, so I cannot comment.

Page 52

ln. 6 Q. In 1991 stiffness in the thoracic-how about limited motion in the lumbar 1991?

A. I have no specific information to that extent.

Q. And then going in 1996, do you have any specific recollection of stiffness in the thoracic on 12-5-96?

A. In 1996, there was no mention either in the history nor in my exam on the record that is available in front of me to that extent.

Q. And finally limited motion in the lumbar spine?

A. In the 1996 record? (12-5-96)

Q. Yes

A. I would have the same comment. There is no description of that either in the history nor in the examination.

Page 55

ln. 9 Q. What was the path of the pulling? (tension in head)

A. The only pulling that we have recorded was in the history what you described as pulling of the facial muscles.

Page 61

ln. 8 Q. Dr.Mancall, on this Thomas Jefferson Encounter form there is a notation about Crohns disease. Did you make any inquiry as to the patient's experience with the Crohns disease?

A. I have no record of that historically on that date.

Page 79

ln. 19 Q. This is an entry made by the acupuncturist. It's an entry of July 1996, chief complaint, pain and stiffness, neck,shoulders and upper back. Would you agree with that assessment as to anything you detected in the 12-5-96 exam?

A. No We received this information not in the history and no substantiation in the exam.

Signed 9-20-02 and noted by Court Reporter.pp. 1-95

University Counsel 2663959
Nov, 3, 1995 1454
Articles of Incorporation
Thomas Jefferson University Hospital, Inc.

First: The name of the corporation is Thomas Jefferson University Hospital, Inc.
Second: The location and post-office address of the initial registered office of the Corporation in this Commonwealth is 111 South 11th St., Phil., Pa. 19107. The Corporation may carry on its activities at several locations throughout the Commonwealth and surrounding area, and may change its principal business address from time to time as the Board of Trustees may determine.
THIRD: The Corporation is incorporated under the provisions of the Nonprofit Corp. Law of 1988.
(a) The Corporation is a nonprofit corporation organized for the following exclusively charitable, scientific and educational purposes within the meaning of 501(c)(3) of the Internal Revenue Code of 1986 as amended or the corresponding provision of any future United States internal revenue law: To own, lease or otherwise hold, manage or operate healthscare facilities and services; including

but not limited to the hospital assets and operations previously owned by Thomas Jefferson University (the "University"); to engage in patient care, education and research in conjunction with the charitable, scientific and educational activities of the University, the University's Jefferson Medical College (the "College"), Jefferson Faculty Foundation ("JEFF") , Jefferson Health System , Inc., (The "System") or others to participate in the organization and development of an integrated non-profit health care delivery system in conjunction with the university, the College, JEFF, the System or others to promote community health and well-being through clinical and statistical research and diseased prevention and treatment; to participate in the education and training of medical students, medical post-graduate students, practicing physicians and other heath care providers through relationships with the University, the college and other academic institutions and teaching hospitals; to develop through experimentation and study more efficient and cost effective systems and procedures for the delivery of health care services to the community and especially to medically underserved populations, and to engage in any lawful act or activities related to the foregoing consistent with the provisions of Section 501 (c)(3)

Sections FOUR TO THIRTEEN OMITTED

Paul C. Brucker MD

Thomas J.Lewis MD

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 5, 2004
BEFORE: HONORABLE LEGROME D. DAVIS, JR.
VIDEOGRAPHY AND TRIAL TRANSCRIPT
PLAYED IN COURT BEFORE HON. JUDGE DAVIS
ON 5-4-04

TRIAL EXAMINATION OF DR. JOHN R WATERMAN
MD- RHEUMATOLOGIST

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
SUITE 300
PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ

PROCEEDINGS RECORDED BY ELECTRONIC SOUND
RECORDING OF KEVIN ASPINWALT OF
HAMILTON COMMUNICATIONS

TRANSCRIPT BY P: TINA DAVIS-BRANDON
REPORTING SERVICE, HARTFORD CONN.

EXHIBITS MARKED FOR EVIDENCE AND ENTERED AT TRIAL

91 Evaluation 9-8-99 pg. 42 Trial Transcript
92 Evaluation 9-8-99 p. 2
93 Patient Encounter Visit Note
94- 95 Letter from Dr.Waterman MD to Dr.Kellman MD pg. 43
96 Central Imaging Associates Medical Exam X-rays 9/99 pg. 43

DIRECT EXAMINATION
BY. MR. MARESCA (PLAINTIFF)

Page 8
ln. 8. Q. State your full name for the record.
ln. 9 A. John R. Waterman
ln. 10 Q. And your address
ln. 11 A. The Newington Campus of the
Veteran's Administration , CONN.
555 Willard Av. Newington, CONN. 6111
ln. 14 Q. Dr. Waterman, could you please provide us with
the year you graduated medical school.
A. University of Vermont 1972
ln. 21 Q. Do you have a specialization beyond general med?
ln. 23 A. Yes.
ln. 24 Q. What is that specialization
ln. 25 A. Rheumatology and internal medicine
Page 9-10

ln. 1 Q. Okay. Did you do your intership in rheumatology
at Johns Hopkins University in Baltimore, MD?
ln. 3 A. Well, technically it's a fellowship. Yes
ln. 12 Q. Have you handled ankylosing spondylitis patients?
A. Yes
Q. Approximately how many of them?
A. Oh. 50-100 maybe.
ln. 17 Q. Dr. Waterman, could you please go through what
you did on 9-8-99 with respect to the examination
of the plaintiff at UCONN.

ln. 21 A. Well, the plaintiff was seen by-initially a medical resident-his name I don't have and was evaluated with a history, physical exam, review of systems, past medical history, medication review, allergy review. And the patient was presented to me as the attending physician.

I then went into the office and clarified a few points in the history, family history, social history etc. And then we discussed our thoughts with the plaintiff. And the result of that was-I would want the plaintiff to get some x-rays, radiographs, which he did. He got them at Central Imaging Associates 1234 Central Park Av in Yonkers, NY

Page 11

ln.4 Q. Dr. Waterman, did you do a Schober test during your visit?

A. Yes, I did.

Q. And what were your findings?

A. Well, the Schober test was abnormal. But I can't give the exact measurements, because the resident did't dictate them in the notes. The normal Schober test is from 10-15 sonometers, so it was something less than that.

Q. Was the Schober less than 5 sonometers?

A. It was less than--it would be less on five sonometers, right. That would be an abnormal Schober.

Page 11-12

ln. 17 Q. Dr. Waterman, could you explain basically to a layperson what a Schober test measures?

A. It's simply a measure of lumbosacral flexion. The measures go from what's called the dimples of Venus, which is L-5, S-1, measure up to 10 sonometers, make a mark, have the patient bend over and try and touch his toes, and the distance that the mark moves is measured in sonometers. So ten, then if it's 5, it would be ten over fifteen, if it's two-it would be 10 over 12. It depends.

ln. 4 A normal Schober's is usually 5 sonometers or greater.

Q. For less than 5 sonometers, what period of time might it take for that patient to get to that stage? Is that something that happens overnight?

A. No, I don't think that happens overnight.

Page 14

ln.1 Q. What caused you to order an x-ray exam of the back?

A. It's usually standard operating procedure when you're dealing with people that complain of back pain to at least get a plain x-ray of the back. So I do it for most patients.

ln. 8 Q. Would part of that rationale be a suspicion of an inflammatory condition?

A. Possibly.

Q. Dr.Waterman, did you write this memo to Dr. Kellman MD in NY which is dated 9-15-1999?

A. Yes

ln.20 Q. Dr. Waterman, if you would very briefly describe why you prescribed Indocin and sulfasalazine, what those medications are intended to accomplish or their substantial equivalent?

A. They're standard-at that--1999, anyway, they were standard medications for the treatment of inflammatory back disease.

Q. So it's your testimony that the purpose of those medications is to deal with an inflammatory process in the back.

A. That is correct.

Q. Also, Dr.Waterman, would you confirm that this spondylitis may be secondary to the inflammatory bowel disease.

A. That is correct.

Page 16-17

BY MR.MARESCA

ln. 13 Q. Dr. Waterman, you mentioned here that the x-rays are compatible with the diagnosis of ankylosing spondylitis?

A. That is correct.

Q. Would it be fair to say that you communicated that to the patient on 9-15-1999? Is that a fair measurement date?

A. As far as I can tell.

ln. 24 Q. OK, you mentioned in this letter, "Those x-rays revealed that he has indeed a spondylarthropathy, which I had suspected." What caused you to suspect a spondylarthropathy?

A. Just some of the general physical findings.

Page 19

ln. 11 Q. Dr. Waterman, you took a regular x-ray or roentgenogram of the back. What will that show?

A. It showed changes of degenerative joint disease, it showed changes that were compatible with ankylosing spondylitis.

Q. Did it show specifically the bony structures and abornalities of the bony structures?

A. Well yeah, that's what an x-ray usually does.

Q. Dr. Waterman, when you examined the patient on 9-8-99 did you ever consider or was it in the medical history that the patient had an inter-ventricular tumor?

A. There's nothing here that even suggests that we asked that question.

Page 20

ln. 6 Q. Dr. Waterman, in considering a plethora of medications, did you ever consider Fiorinal?

A. No.

ln. 20 Q. Dr. Waterman, in examining the patient did you turn the head from left to right?

A. Yes

Q. Did you find a normal range of motion?

A. No. As I mentioned earlier, there was decreased cervical range of motion in all directions.

Page 21

ln. 1 Q. And at the point of making that finding what did you suspect?

A. That the patient had some sort of cervical spine disease.

Q. Is that a realistic suspicion on the part of the physician?

A. Absolutely.

Q. Did you move the patient's head up and down.

A. Yes. As I said, he had decreased cervical range of motion in all directions, so up, down, sideways, right , left.

ln. 13 Q. When you moved the neck from right to left, did you meet with any resistance?

A. All I can tell you is what is written down here. As I said before, decreased range of motion in all directions. So when you move the neck -it only goes so far and then it stops.

Page 24 Q. Nutrition question on ankylosing spondylitis

A. Outside of a balanced diet, there's no nutritional treatment of ankylosing spondylitis I'm aware of.

Page 34 Cross Examination Excerpt of Bradley Goewert,Esq

ln. 22 Q. Now, in your examination of him-you examined his neck and back because he had had some complaints of neck and back stiffness, right?

A. That is correct.

REDIRECT EXAMINATION

Page 41

ln. 6 Q. Dr.Waterman, you've indicated to Dr.Kellman in your memorandum, "Mr.Maresca's a gentleman with a great deal of musculoskeletal complaints" What does that mean generally? Could you expound upon that?

A. What does it mean to me? It just means that you conveyed a lot of achiness.

Page 42

ln. 4 Q. The last item, Dr.Waterman, do you waive the signing and allow the transcript to be presented to the Court as is.

A. Fine with me.

VIDEOGRAPHER-That concludes this testimony. Going off the record at 5:38 PM.

PLAINTIFF'S EXHIBITS 91-96 marked for identification.

Analysis: Dr. Waterman MD-Rheumatologist attests to a bone disease, gross range of motion problems, the need for an anti-inflammatory protocol and the fact that an interventricular tumor was never considered. P.63 "There's nothing here that even suggests that we asked that question. " This is significant because Dr.Mancall's hypothesis was an interventricular tumor. For this, he took an expensive MRI of the brain which showed cerebellar atrophy . There's nothing in the record indicating any followup of the cerebellar atrophy by Dr.Mancall MD. There are 3 classic cerebellar atrophies in medicine. These are Olivopontocerebellar Atrophy, Parenchymatous Atrophy of the Cerebellum and Primary Degeneration of the Corpus Callosum (Marchiafava's Disease of the Mediterranean peoples).. Nowhere in Dr.Mancall's record is there any notation of his analysis of the type of cerebellar atrophy found. A.50; A.118; A.119 & A.122

Trial Exhibit 93-Approved by Court

University of Connecticut Health Center
Farmington CT. 06030

PATIENT ENCOUNTER VISIT NOT TEACHING
PHYSICIANS CONTINUED PROGRESS NOTE

HPI: Neck stiffness
PE: & C spine & schober

DX: probable cervical & lumbar spondylosis

PLAN: L/S & C spine

John R. Waterman MD--Teaching Physician's Signature

Trial Exhibit 94 Admitted by Court
UCONN MEDICAL GROUP
RHEUMATOLOGY ASSOCIATES
September 15, 1999
Dr.Raphael Kellman
124 East 36th St, NY 10016

RE: Joseph S. Maresca
MRN 881837

Initialled by Dr. Kellman MD 9-28-99

Dear Dr.Kellman,
I had the opportunity of seeing Mr.Maresca at UCONN Division
of the Rheumatology Clinic on 9-8-1999. As you know, Mr.Maresca is a gentleman with a great deal of musculoskeletal complaints. In addition, he has a history of inflammatory bowel disease.. When he came to see me, the only information available to me was his own notes regarding various types of procedures and analyses that had been performed on him. My understanding is that you have training in both internal medicine and holistic.

After my examination, it was evident that Mr.Maresca had marked decreased range of motion of his axial skeleton. Consequently, I obtained some radiographs performed at Central Imaging Associates on 1234 Central Park Av. Yonkers NY . Those x-rays revealed that he does, indeed have a spondylarthropathy, which I suspected. His x-rays are compatible with a diagnosis of ankylosing spondylitis. In addition, this type of spondylitis may be secondary to the aforementioned history of inflammatory bowel disease.

I spoke with Mr.Maresca today (9-15-99). I told him that he would probably benefit from either a nonsteroidal anti-inflammatory (Indocin) or sulfasalazine. He has been on sulfasalazine in the past for his inflammatory bowel disease and actually tolerated it quite well. I instructed him to get in touch with you since he regards you as his primary care physician. I feel uncomfortable prescribing medications like this from such a long distance. It would be impractical for him to come to the UCONN in Farmington, CONN., on a regular basis for monitoring of these medications. I also mentioned the fact that he could, perhaps, be referred to a local rheumatologist who then could monitor his care.

The dose of indomethacin that is usually used for spondylarthropathy is 50 mg t.i.d. Sulfasalazine is given in a total dose of approximately 2-3 grams per day, usually in divided does (b.i.d.) Both those medications have been shown to
be effective in the treatment of inflammatory back pain.
Sincerely,
John R. Waterman, MD-Assistant Professor of Medicine
Dictated by John R. Waterman MD
TRID 9909152232513504O0 DP 9-171999 12:05DD
9-15-99 18:37 DT 9-17-1999 11:55 TID 10982

Trial Exhibit 96-Approved by the Court

Central Imaging Associates

9-9-1999
RE: Maresca, Joseph S.
D/Exam 9-9-1999

John R. Waterman MD
263 Farmington Rd
Farmington CT 06030 DOB 1-14-1952

CERVICAL SPINE WITH OBLIQUE VIEWS:

AP, lateral and both oblique views were obtained.
There is evidence of ossification of the anterior longitudinal ligament with bridging syndesmophytes noted. There is no foraminal stenosis. Disc height is preserved. There is suggestion
of multilevel facet fusion. No prevertebral soft tissue abnormality
is noted. The C2-C2 articulation is normal.
IMPRESSION:
Ossification of the anterior longitudinal ligament and findings
consistent with multilevel facet fusion. Differential diagnosis for these findings including ankylosing spondylitis as well as other seronegative spondylarthropathies.

Trial Exhibit 96 - continued

LUMBOSACRAL SPINE:
AP, lateral and a coned down lateral view of L-5-S1 were obtained. There is ossification of the anterior longitudinal ligament
with evidence of extensive syndesmophyte formation at multiple
levels. There is preservation of disc height except at L4-L5 and L5-S1 when there is mild disc space narrowing noted. There is multilevel facet overgrowth and calcifications of the infraspinous ligaments. Alignment is within normal limits. There is fusion of the sacroiliac joints. No periarticular erosions
are seen. The symphysis pubis is intact.
IMPRESSION: Multilevel syndesmophytes with ossification of the anterior longitudinal ligament.

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 5, 2004
BEFORE: HONORABLE LEGROME D. DAVIS, JR.
VIDEOGRAPHY AND TRIAL TRANSCRIPT
PLAYED IN COURT BEFORE HON. JUDGE DAVIS
ON 5-4-2004

TRIAL EXAMINATION BY VIDEO OF:
CREATED: MARCH 30, 2004 begins 11:04AM-11:27AM
DR.RAPHAEL KELLMAN, MD-INTERNIST
124 EAST 36TH STREET, NY

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
SUITE 300
PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ
PROCEEDINGS RECORDED BY EDWARD FORD
CERTIFIED LEGAL VIDEO SPECIALIST
TRANSCRIPT BY :SANDRA NOEL BARTELS-COURT
REPORTER- AND NOTARY PUBLIC.

EXHIBITS MARKED FOR EVIDENCE AND ENTERED AT TRIAL

Exhibit 69 Letter, page 1 of 2, 9-15-99
Exhibit 70 Letter page 2 of 2 9-15-99
[Letter from Dr.Waterman MD-Rheumatologist to Dr.Kellman MD-Internist and treating physician outlining the diagnosis of ankylosing spondylitis and inflammatory treatment
Exhibit 71 Glycemic Challenge Profile
Exhibit 72 Lab 2-14-2000
Exhibit 73 Lab 5-21-99
Exhibit 74 Encounter form 5-11-99
Exhibits 75, 76 Web documents
Exhibit 77 Invoice 4-28-2000
Exhibit 78 Invoice 9-24-99
Exhibit 79 Invoice dated 9-24-99
Exhibit 80 Invoice dated 10-21-99
Exhibit 81 Invoice dated 11-17-99
Exhibit 82 Lab 2-10-2000
Exhibit 83 Invoice dated 3-30-2000
Exhibit 84 Invoice dated 4-4-2000
Exhibit 85 Invoice dated 4-13-2000
Exhibit 86 Invoice dated 5-30-2000
Exhibit 87 Invoice dated 6-22-2000
Exhibit 88 Invoice dated 3-29-2000
Exhibit 89 Lab report dated 5-21-99
Exhibit 90 Lab, collection date 4-15-98

RAPHAEL KELLMAN MD, called as a witness having been duly sworn by a Notary Public, was examined and testified as follows:

Page 6

Ln 7 Q. Dr. Kellman, please state your full name & address for the record. (Questioning by Plaintiff-Maresca-Pro-se- Appellant)

A. Dr.Kellman MD at 124 East 36th St. NY 10016.

Q. Dr.Kellman, are you a graduate of Einstein Medical School?

A. Yes

Q. And you specialize in internal medicine.

A. Yes

Q. Dr.Kellman, if you would look at Exh. 69, a letter dated September 15, 1999 to you.

A. Yes

Q. From Dr. John R Waterman MD.

A. Correct.

Q. Have you read this letter?

A. Yes

Page 7

ln. 7 Q. Dr. Waterman is mentioning a diagnosis here of ankylosing spondylitis. Do you concur with that diagnosis?

A. I could just tell you what he said. You know, I'm not a rheumatologist to make such an extensive diagnosis

Q. Well, he is recommending treatment--

A. Well , based on his premise, then his treatment would make sense. Again, I'm not a rheumatologist to make these types of diagnoses.

Page 7-continued

ln.20 Q. He's recommending an anti-inflammatory, indomethacin and sulfasalazine. What do these medicines accomplish?

A. They reduce inflammation.

Q. And in your practice, did you prescribe that for the patient or did you prescribe something of another nature?

A. Well my approach is more natural and I would use natural anti-inflammatory agents, agents that improve a deeper underlying cause.

Q. Which anti-inflammatory agents did you choose? Okay, I have exhibits here. Let's see if we can go to Exhibit 77 first. This is showing a description of Intestamine. What would Intestamine accomplish?

A. That would reduce--that would improve gastrointestinal function, specifically the gastrointestinal wall, the function of the cells of the gastrointestinal wall so that there would be less inflammation and less permeability to potential toxins and agents that can evoke the immune system to create an inflammatory state.

Q. Okay. Also, I'm showing on Exhibit 83, you're using Vitamin C and Magnesium drips.

A. Yes,

Q. What will that accomplish?

A. Well Vitamin C does many things.

Page 9

ln.4 A. It improves the immune (system). It can also be an anti-oxidant in low doses which can then improve free radical development. Magnesium also has many functions. It can improve cardiac function. It can improve muscle function.

Q. Also, Dr.Kellman, with respect to the treatment modalities that would be helpful for musculo-skeletal complaints that Dr. Waterman is mentioning on Exh. 69, would you recommend acupuncture, would that be helpful?

ln.22 A. My belief is that acupuncture can help many conditions in a general way in that it improves the ecology of the body.

Page 10-11

ln. 17 Q. Dr. Kellman, did you perform this glycemic challenge profile in Exhibit 71?

A. Yes.

Q. What did that show?

A. It shows that you have a very high glucose level and a high insulin level and it is consistent with diabetes.

Q. How did you treat that?

ln. 25 A. Well, we recommended a drug called Avandia, weight loss, dietary intervention, exercise, mild exercise and a few supplements that also improve glucose control.

Page 11-12

ln. 5 Q. Okay, Dr.Kellman, did you see this Exh. 73, yeast profile?

A. Yes.

Q. Do you believe that yeast was important to-- or the elimination of yeast would have been helpful in my program of treatment?

A. Well, you know , that's a controversial issue. I think there is evidence for the notion that there is a connection between yeast, Candida, and byproducts of Candida, and various physiological abnormalities. And therefore, the control of yeast overgrowth can help improve various abnormal physiological states.

Page 12

ln. 12 Q. I would like to get very quickly back to Exh. 69 and here Dr.Waterman is mentioning to you X-rays compatible with ankylosing spondylitis.
Is this 9-15-1999, the first date or the earliest date that the process ankylosing spondylitis was ever mentioned to you or discussed with the patient; is this a fair date (for measurement purposes)?

A. Yes.

Page 15

ln. 11 Q. Did any of your treatments deal specifically with inflammation?

A. Yes. The use of intestamine, Vitamin C. I don't remember offhand the other supplements that we gave, but the control of glucose and insulin, hyperinsulemia, high levels of insulin, in and of itself reduces inflammation.

Page 18- Cross Examination Excerpts of Mr.Goewert,Esq.

ln. 14 Q. Now, Dr.Waterman was a rheumatologist who saw Mr.Maresca in September 1999 and he had recommended a non-steroidal anti-inflammatory, indomethacin and sulfasalazine. Now do you prescribe those types of medications in your practice?

A. Infrequently.

Page 19 On re-direct by Maresca- Pro-se Plaintiff

ln. 24 Q. On redirect, just one item to complete. The hair analysis you would have completed on 4-29-1998. Is that a fair date?

A. Yes

Q. So that at least by that time you would have been seeing me.

A. Correct

THE VIDEOGRAPHER: The time is 11:27 AM on 3-30-04 This is the end of Tape 1 and this completes the videotape of Dr. Kellman MD-Trial Exam.

Trial Exam Exhibits 69-70 are a 9-15-1999 letter from Dr. Waterman MD-Rheumatologist to Dr. Kellman MD advising him of the ankylosing spondylitis finding and the treatment protocol of indomethicin and sulfasalizine for internal inflammations. This letter is in the Trial Exam of Dr. Waterman.

Exhibit 71, 72-Approved by the Court

Glycemic Challenge Test by Diagnos Techs Inc.
Clinical and research Lab
Third Quarter 1999
Severe Pre-diabetic state
Insulin Resistance
Recommend: Glycemic dietary control
Avandia 4 mg. / day
Biogymnematid

Trial Exhibit 72- Approved by Court

KCPM Labs
124 E. 36th St.. NY 10016
212-532-0600
Raphael Kellman MD, Lab Director
Name: Maresca, Joseph S. 011452 Sex M
Phone: 914-649-3817
Drawn : 2-10-00

General Chemistry: Glucose 121 Ref. Range 65-125

Trial Exhibit 73 -Approved by Court

Microscopic Oxidative Stress Test (MOST)
(HighResolution Phase Contrast, Dark Field and Light Microscopy of Peripheral Blood Smears Blood Yeast and Microbial Assessment on TV Screen)

D-Decreased PLF-anaerobic microbes

Maresca, Joseph S. 5/ 21/ 1999

Rouleau	+1
RBC Crenation Spikes	+1
RBC Membrane Damage	+1
RBC Lysis	+1
Lymphocytes I/D/N	D
Lymphoblasts	+3
Platelets	D
PLF'S Pale	+4
PLF'S dark	+4
PLF-Hyphae Black & Wh	+2
Yeast Pattern	+4
Viral Pattern Chronic	+1
Oxidative Coag	+4
AA Oxidopathy	
Total Stress	+4
Crystals and Misc.	+2

Pathologist: Dr.Magid Ali MD
140 West End Av. Suite 1H NY NY 10023

Trial Exhibits 77-89 Under Advisement by Court
in the Appellate Record
Dr.Kellman's Treatments
for Inflammation

Exh. 77 Intestamine and IM Injection 4-28-2000

Exh 78 Blood Chemistry Metabolic Panel,
CBC,Lipid,VLDL,
Creatinine, Prostate , TSH , T-3, T-4, Free T4,T
uptake
H-Pylori and APO Lipoprotein $380. 9-24-99

Exh 79 Vitamin Infusions and Extended Office Visit
9-24-99
$190

Exh. 80 Glucose and Insulin Tolerance Office Visit $837.

Exh 81 Intestamine 360 GM and Office Visit $90.

Exh. 82 Glucose General Chemistry at 121 level 2-14-2000

Exh 83 IV Drip vitamins and Magnesium $30 3-30-2000

Exh. 84 Vit C and Magnesium drips $30. 4-04-2000

Exh. 85 Vit C and Mag. Drips $30.4-13-2000 4-13-2000

Exh 86 Vitamin Drips $30. 5-30-2000

Exh. 87 IM Injections, Ultra Fiber $30 6-22-2000

Exh. 88 Colonic hydrotherapy 6 visits $500. 3-29-2000

Exh. 89 Smithkline Beecham Clinical Labs 5-21-1998-Stool
Concentrate Result-No Parasites Seen
Trichrome Result- No Parasites Seen

Exh. 300 Great Smokies Diagnostic Lab-Hair Analysis 4-21-
98
Toxicities Found: Lead 3.46; Magnesium 16.18 on
a 30-70 Ref. Zinc at 105 s/b 110-163;
Cobalt .005 s/b .01 ; Iodine 0 s/b .11
Stronium .2 and s/b .25; Ca. 210 s/b 215-780

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 5, 2004

BEFORE: HONORABLE LEGROME D. DAVIS, JR.
VIDEOGRAPHY AND TRIAL TRANSCRIPT
PLAYED IN COURT BEFORE HON. JUDGE DAVIS
ON 5-5-04 AND 5-6-04

TRIAL EXAMINATION OF DR. MITCHELL FELDER MD
NEUROLOGIST-EXPERT WITNESS

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
SUITE 300
PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ
TRANSCRIPT: TINA DAVIS-BRANDON REPORTING
PROCEEDINGS RECORDED BY ELECTRONIC SOUND
RECORDING OF KEVIN ASPINWALT OF
HAMILTON COMMUNICATIONS

Swearing in of the expert witness by Ms. Moore-Notary & Transcriptionist

Page 6 Direct Examination by the Plaintiff

ln. 5 Q. By Mr. Maresca (Plaintiff)
Would you state your full name and address.

A. My name is Mitchell S. Felder, MD. I'm at Suite 2 87 Stambaugh Av., Sharon Penn. 16146.

Q. And Diplomate Felder, which medical school did you attend.

A. I a graduated from the University of Rome Faculty of Medicine.

Q. And what year was that ?

A. 1983

Page 7

ln. 1 Q. Also, when did you get a designation as Diplomate?

A. Well, I passed two Board exams. One was the American Academy of Clinical Neurology, Dec.'90. I'm Board Certified in Neurology by the American Board of Psychiatry and Neurology in April 2000.

Q. If you could explain briefly what is a Diplomate and what additional training is involved?

A. Well, I had to-I was an intern qualified for neurology. I then did-I was a resident in neurology at St.Vincent's Hospital in Manhattan. I was chosen to be the Chief Resident in Neurology. After that, one takes a Board exam, which is a multi-faceted exam, both written and oral, which shows competency in the subject of neurology.

Page 7

Ln. 17 Q. How much does a-does a Diplomate distinguish from a person-just a regular neurologist in your view?

A. I would think a knowledge of and competency in the field of neurology.

Page 8

ln.1 Q. Okay, if you could quickly go over the hospitals you've worked for?

A. Of course, I was at Englewood Hospital, in Englewood, NJ as an intern. I was then a neurology resident at St.Vincent's in Manhattan. I then came to this area, Sharon Regional Health Systems, which was called Sharon General Hospital. And since the last 5 years, I've been at UPMC Horizon Campus, University of Pittsburgh Medical Center.

Q. Have you handled many hospital records in your experience?

A. Yeah, definitely.

Q. Encounter forms and patient records, things of that nature?

A. Yes, I have

Q. Are you comfortable with what an acceptable standard in the preparation of a record should be from your experience in working in hospitals?

A. Yes

Q. Okay, if you could go over your experience as a disability examiner.

Page 9

ln. 1 A. I've been a disability examiner for the Social Security Disability part of the government, of course and that's been since 1990 to the present. That's involved in examining patients, writing a report. I don't decide specifically what is their disability from the Social Security Disability Office, but then I write a report that the Social Security Disability Examiner Office decides whether or not to classify the person as disabled.

Q. Have you handled cases of the spine?

A. Yes

ln. 12 Q. Have you handled cases involving cerebellar atrophy?

A. Yes

Q. Have you handled cases involving ataxias?

A. Yes.

ln.22 Q. Okay. With respect to the different spheres of the brain, you're comfortable in analyzing those?

A. Yes. That's again, part of generic neurology.

Page 10

ln. 7 Q. Also, Diplomate Felder, have you ever worked with an acupuncturist in your career?

A. Tangentially, I sent patients to see an acupuncturist from my office for chronic pain.

Q. Okay, and have you had a good experience in terms of your sending patients to acupuncturists?

A. Fairly good, yes.

Q. Are you comfortable in having an acupuncturist treat a person?

A. Yes, I am

Q. Do you believe that acupuncture has any scientific validity?

A. Yes, I do. I'm not exactly sure whether it increases endorphins or is affecting the nerve transmission & in what way, but I believe it does have some validity.

Q. Diplomate Felder, have you ever handled patients formerly in Europe, as well as the United States?

A. Yes

Page 12

Ln. 3 Q. Okay. All right. Diplomate Felder, if you would kindly get into the details of the work you performed in analyzing the various medical records and depositions put before you.

A. I reviewed the records, the deposition of Dr.Mancall, deposition of Mr. (Diplomate)Deng, and the deposition of Dr.John Waterman, which you can see right here. These are-this is what I reviewed.

Q. Okay. And in reviewing those depositions if you would refer to Diplomate Deng because that is his title.

A. Yeah. Diplomate Deng

My- after reviewing this, it was my conclusion that

ln. 18 A. the patient's head movements were not examined, nor was the -there to my knowledge reviewing these documents in my medical opinion, an examination of the spine.There was no recollection of the patient's position. There was deficiency of looking at neck posture. There was deficiency in not looking at neck posture. There was no evaluation of the pelvic area.

Page 13

ln.1 There was no exam to my knowledge of rotation of the thigh.

The patient, yourself , Mr.Maresca was given a diagnosis of chronic tension headaches at the time. I reviewed, of course, Dr.Mancall's testimony and this sheet here, which is the sheet from the Thomas Jefferson University Hospital physical exam. It's somewhat difficult to read, but you know, you see motor deep tendon reflexes.

ln. 12 Q. On 12-5-96, did Dr.Mancall make a correct diagnosis?

A. No. It is my medical opinion, that the correct diagnosis would have been ankylosing spondylitis.

Page 13 continued

ln. 17 Q. What causes you to have that opinion?

A. A number of problems. First of all, that there was an insidious onset of the condition as per Harrison's Principles of Internal Medicine, duration greater than three months, morning stiffness. There was some improvement with exercise or activity, from what I read in the record of the testimony. And the fact that of course that the correct diagnosis was achieved by Dr, Waterman at a later date.

Page 14

ln.1 Q. In your opinion, did Dr.Mancall take the correct test?

A. No. It's my medical opinion that the correct test wasn't performed at that point in time and that one possibility would be an MRI of the sacroiliac area. Something else would be-that could possibly be used is what's called HLA-B27, histocompatibility antigen. Of course, x-rays. As per Harrison's Textbook of Medicine, MRI has emerged as a specific technique for identifying intraarticular inflammation, cartilage changes in sacroilitis. This is what I know, reviewed in Harrison's Principles of Internal Medicine 15th Edition.

ln. 24 Q.Dr. Felder, in your opinion from reviewing Harrison's Textbook on Internal Medicine, do you believe that that book has scientific validity? And if so, why?

A. Without question, it's the major textbook in the United States for the study and practice of Internal Medicine. It's written by a plethora of top authorities, and it's hard to imagine a better text.

Page 16

ln. 1 Q. Diplomate Felder, I would like to get back to the testing. You indicated that Dr.Mancall took the MRI of the brain and that he should have taken the roentgenogram of the back, is that correct?

A.That's correct.

X-ray of the back, or better yet would have been MRI of the sacroiliac area.

Q. Now in taking the MRI of the brain, did Dr.Mancall document his analysis of the result of the MRI of brain?

Let me show you these two exhibits. Exhibit 44 is the order for the MRI of the brain, and Exh. 45 is the MRI of the brain.

A. Yeah, this is--

Q. Diplomate Felder, have you ever seen these exhibits?

A. Yes, I believe so.

Q. Okay.

A. And the impression of course is cerebellar atrophy.

Q. Now with a finding of cerebellar atrophy, do you see on the Thomas Jefferson University encounter form any evidence that Dr.Mancall came to a conclusion on whether or not the cerebellar atrophy was problematic?

A. I can't recall that he did come to that conclusion that it's problematic.

Page 17

ln. 16 Q. Dr.Felder, are you qualified to understand what cerebellar atrophy means?

A. Yes, it's atrophy of the cerebellum.

Page 18

ln. 12 Q. So would it be safe to say that you really-- you have no way of knowing what conclusion or what documented conclusion Dr.Mancall came to from looking at the face of the Thomas Jefferson University encounter form?

A. That is correct.

Page 19

ln. 3 Q Should that encounter form list his analysis of the MRI of the brain?

A. Yes. One--a physician can put the reference to a report of the brain -on an encounter form.

Q. Okay. Also, is there any evidence on the face of the form as to whether or not Dr.Mancall did a comprehensive analysis of gait?

A. No, I cannot find exactly a-I can't see the word gait on this form.

Q. In your opinion, would a comprehensive analysis of gait help in coming to a diagnosis of ankylosing spondylitis?

A. Yes, it could help.

Page 20

ln 1 A. It would indicate to a physician that there is a problem with ambulation with--and lead to possibly further testing. It's a classic part of a neurologic exam, a description of gait.

ln. 23 Q. And also, could you tell me whether or not the dorsal lobules displayed more severe atrophy than the lateral hemispheres.

A. I can't see that on the form.

Page 22

ln. 12 Q. Okay. Is there any indication on the face of the Thomas Jefferson University encounter form that Dr. Mancall monitored the use of Fiorinal, or in fact, if he knew that it was ever prescribed?

A. I can't specifically say that I see that.

Q. Should there be that kind of evidence or notation?

Page 23

ln. 1 A In my opinion, my medical opinion, I believe there should be a follow-up visit after a visit such as this. That's my opinion.

Q. Okay. There are three subsequent letters that the patient sent to Dr. Mancall and that he has admitted to reading. Have you reviewed those letters?

A. Yes. They're in here. That's part of the record here.

Page 24

ln. 18 A. It's my opinion that a patient-I'm sorry, a physician receiving a letter from a patient should respond to the patient in some form, written or oral. Your telephone number is on the letter.

Q. Is there any evidence on the face of the Thomas Jefferson University Hospital encounter form, which indicates that Dr.Mancall made any attempt to contact the patient?

Page 25

ln. 3 A. I don't know of such evidence.

Q. And if we could back track , a minute, you have testified ,Diplomate Felder, that Dr.Mancall should have done some followup with respect to the patient.

A. That's my opinion.

ln. 20

Q. Okay. Specifically, in your medical opinion, should there be a notation on the Thomas Jefferson University encounter form with regard to the letter of February 9, 1997?

Page 26

ln. 3 Q. This is exhibit 46

A. Exhibit 46, yeah. See this is covered up here. That's what's giving me a problem. Perhaps that's one thing, but typically physicians will call the patient and then write a note in the chart, making reference to the letter, which would also typically be in the chart.

Q. Did you-have-did you see any evidence of a notation of attempts to call the patient in the chart?

A. I don't recall seeing any of that.

Page 28

ln.7 Q. Diplomate Felder,have you seen this letter of 2-15-97 addressed to Dr.Mancall? Exhibit 47

A. It's a letter from you to Dr.Elliot Mancall, stating that they had-you-the two of you had discussed the MRI, showing cerebellar atrophy; that you had seen Dr.Filannino, who prescribed Imitrex at 25 milligrams to treat headaches; that you don't have tingling in the fingers; and that the tension in your upper pallate of the mouth has reduced significantly, but that you still have tension in the forehead, which worsens at night.

It goes on to say that you and Dr. Filannino had discussed increasing the dosage to 50 milligram pills and that this option might clear up the remainder of your headache and that you--we, referring to yourself and Dr.Filannino would have to try another medication or combination of medications. You then go on to ask if Dr.Filannino should do arteriography.

Page 29

And you later state that you'd like at least two physicians to examine the films in detail to come to the same or similar conclusions, and that you stated that you were concerned that the MRI has been taken and

ln.8 interpreted properly.

ln9. Q. Okay, upon reading this letter, what would your reaction be to that letter as a neurologist?

A. I would in my practice, most probably contact the patient and ask the patient to come in for a followup visit.

Q. Do you see any evidence on the face of the Thomas Jefferson University Hospital encounter form which accomplishes what you've just suggested?

A. No. I don't see any specific evidence of that.

Q. Should there be some sort of evidence of that, in your medical opinion?

A. Well, it's my opinion that receiving--having received letters, in general, a physician should respond to the letters and contact the patient and possibly have follow-up visits with the patient.

Page 30-1

ln. 3 Q. And I'm going to give you the final exhibit 48, which is a memo written also addressed to Dr.Mancall, the last memorandum of its kind, on 2-27-97 or that's what it looks like at the bottom.

A. Yeah

Q. If you could summarize what is in there?

A. Well again, you're saying that you saw Dr.Filannino He had increased the dosage of your medication, I would gather of Imitrex, which is sumatriptan to 50 milligrams a day, that you were not having permanent relief of the headache except at night when you were lying down. The Imitrex did appear to relieve the tingling in the fingers. However, the tightness of , as you put it, trigeminal nerve structures continued unabated. You then mentioned a use of Haldol or Robaxin or one of the muscle relaxants; that you have a personal acupuncture appliance which delivers measured electrical stimulation to the forehead; and that it is not a permanent solution. And then you finally conclude in the third paragraph, Kindly consider all of the above and advise me -as to which direction might provide me a permanent resolution of this headache. Signed by yourself, with your telephone number.

Q. In your medical opinion, what should Dr.Mancall have done upon receiving this letter?

A. It would be my opinion that a physician receiving a letter from a patient of this nature should call the patient and/or schedule a follow-up visit.

Q. Do you see any evidence on the face of the Thomas Jefferson University encounter form that that was done?

A. No I don't.

Q. Or even attempted?

A. No, I don't see an indication specifically of that.

Page 32

ln. 11 Q. Okay. Dr.Felder, I'm giving you Exhibit 49, which is a memo prepared by myself and taken to the 12-5-96 encounter with Dr.Mancall to which he has admitted receiving and reading in his deposition . OK this letter mentions the permanent restriction in the ability to do sit-ups or to run at maximum speed.

A. That is correct.

Q. Diplomate Felder, in your opinion given this type of complaint, what would you do?

A. In my opinion, I would follow up with a patient until there was a specific diagnosis of their condition and/or they were having some improvement in their condition.

Page 33

ln. 1 Q. Specifically, is there a diagnostic test you would take to evaluate that complaint?

A. Well, certainly x-rays of the back. Again one could consider MRI of the sacroiliac region as per Harrison's Principles of Internal Medicine.

Q. Do you see any evidence on the face of the Thomas Jefferson University encounter form that indicates that Dr.Mancall considered any of those things?

A. I don't see such a thing.

Q. And also, if you could repeat the diagnostic test that you think should have been taken?

A. An MRI of the sacroiliac area, x-rays of the lumbo-sacral area, blood tests for HLA-B27 could have possibly been taken.

ln. 20 Q. And, Diplomate Felder, in taking those specific tests do you believe that any one of those would have lead to the discovery of ankylosing spondylitis?

A. It's my opinion that, yes that would have given a strong indication.

Page 34

ln. 1 Q. And could you attach the likelihood that it would have given a strong indication of ankylosing spondylitis?

A. In my opinion, within a reasonable degree of medical certainty, it would have given that in my opinion.

Q. Okay, Also in your medical opinion, did Dr. Mancall ever analyze the path of the tension headache or the spinal root distribution?

A. I don't recall that being done.

Page 35

ln. 8 Q. Okay. Diplomate Felder, do you see any evidence on the face of the Thomas Jefferson University encounter form that Dr.Mancall ever attempted to contact the successor physician in this case Dr. Filannino?

A. I do not recall such a statement.

Q. Is there anything on the face. [of the encounter form?

A. Such a record, no, I don't remember seeing that.

Q. Diplomate Felder, do you believe that it would have been important for him to communicate with the successor physician?

A. Yeah

Page 36

ln.8 Q. -if you could put in front of you, the record of the rheumatologist-Dr.Waterman?

A. The deposition of Dr.Waterman?

Q. Yes, both the deposition, as well as Dr. Waterman's encounter form and his letter to Dr. Kellman.

Page 37

Q. This is Dr.Waterman's roentgenogram of the back-taken in September 1999.

A. Well, you have a cervical spine with oblique views, with a the impression of ossification of the anterior longitudinal ligament, findings consistent with multi level facet fusion.

A differential diagnosis for these findings would include ankylosing spondylitis, as well as other seronegative spondylarthropathies. There's also a lumbosacral spine showing ossification of the anterior longitudinal ligament, mild disk space narrowing, overgrowth in calcifications, fusion of the sacroiliac joints. What's-that's basically it.

ln. 19. Q Okay. If you could review for us what is an ossification?

A. It's a bony--a formation--increased bone formation, like from the word ossify.

Q. And what are the implications of that for the patient.

A. Could be chronic inflammation, increased calcium formation.

Page 38

ln.10 Q. There's a suggestion of multi-level face fusion. What is that?

A. That's different levels where the facets of the vertebrae are fusing , are coming together tightly.

Q. And the impression, it says differential diagnosis of ankylosing spondylitis and other seronegative spondylarthropathies ?

ln. 20 A. Well, that's indicative that the ankylosing spondylitis is the differential diagnosis.

Page 39

ln. 1 Q. And in the lumbosacral spine, it has again ossification of the anterior longitudinal ligament, with evidence of extensive syndesmophyte formation at multiple levels.

What does that mean to a lay person?

A. Again, there is inflammation and chronic-there's chronic inflammation with a decrease in intertissue space.

Q. Underneath, it says there is a multi-level facet overgrowth and calcifications of the infraspinous ligaments. What does that mean to a layperson?

A. There's more calcium there than one would expect.

Q. And then going further down, there is fusion of the sacroiliac joints. What would that mean to a layperson?

A. The sacrum and the ilium are fused. They've been brought together.

Page 41

ln.1 Q. Diplomate Felder, did you read Diplomate Deng's Deposition?

A. Yes, I did.

Q. Completely?

A. Yes, I read it.

Q. The Aug. 20, 2002 deposition [filed with the D.C.]

A. Yeah. Telephonic deposition of Diplomate Charles Deng.

Q. And in reading the deposition, did you rely upon the deposition in formulating your opinion as to the existence of ankylosing spondylitis as of 12-5-96?

A. I believe yes, that was an element in coming to that conclusion.

Q. How much of an element would it have been?

A. It's hard to say. I'd say some element, 20 , 30%, I really don't know. It was a compilation of materials.

Q. Okay. With your permission, I'd like to just read some of what Diplomate Deng testified to on 8-20-02.

Counsel Objection

MR.MARESCA. Okay. But I will advise the Court that Diplomate Felder has indicated that he has considered Diplomate Deng's deposition in coming to his conclusion and so I think that it will lead to material helpful to the Court.

Page 42 Plaintiff deposing Diplomate Deng on 8-20-02

ln. 4 Q. Okay, On Page 13, starting on Line 3- and this is a quotation, and I'm going to read approximately a 1 1/2 pages.

Q. Okay, In your observation (Diplomate Deng), did you observe stiffness in the first meeting and subsequent meetings? Back on 7-6-1996, was there stiffness.

A. Answer on ln. 7, I did not catch your question exactly.

ln.9 Q. Yes. When you examined the patient

A. Yes

Q. Did you find stiffness particularly stiffness of the head, stiffness of the neck and shoulders?

Q. Did you find stiffness of the head?

A. Stiffness of the head, yes. That's the patient's chief complaint.

Q. Was there stiffness of the neck?

A. Yes.

Page 42-continued

Q. Was there stiffness in the shoulder?

A. Yes

Q. Was there stiffness in the spine?

A. Yes

Q. So you found a general stiffness in the head, neck the shoulder and spine.

A. That's right. That's true.

Q. In addition, did you turn the patient's head from left to right?

A. Yes, I did , yes.

Q. And in turning the patient's head from left to right, what did you find?

A. I found the patient had a limitation of movement of the spine limited to turn left and right.

Q. When you turned the patient, did you turn the patient's head from right to left in the other direction?

A. Yes, I did.

Q. And what did you find?

A. From left to right, the patient have about 10 degrees of movement. It's about 10-15 degrees of movement. On the left side , it's about 10 degrees.

Page 43-44

ln. 16 Q. And was that helped by the acupuncture treatment?

A. By the time of the treatment, I find that they talk about calcifying of the ligaments and the spine, and I recommend the patient to see a specialist. Yes, after I found the stiffness of the spinal cord and I recommend him to check with his medical doctor, and I said this will be related to some other problem and only do--
and I only can do this to relieve his stiffness of muscle and the headache problem by the moment. The patient agreed and continued for the treatment for relieving the stiffness of the shoulder and headache.

Q. Diplomate Deng, did you ever at any point have the patient lie completely flat on the examining table?

A. By that time I asked--I did ask him to lie down, and the patient had difficulty to move. Have to step on a stool and then he can lie down on the bed.

Q. Now, when the treatment was finished, did the patient get up on his own, or did he have to--
-did you have to help the patient get up?

A. Of course, I have to help the patient.
The patient is difficult to lift by himself, and I help him to lift up. Then, he can stand up.

Q. So that in every case where the patient was lying on the examining table and the acupuncture was finished, you had to help the person, you had to help the patient sit up?

A. Yes

Page 45

ln. 10 Q. In the first examination on 7-6-96, did you get a chance to view the patient perfectly flat on the examining table, in other words lying down flat?

A. Well, the patient has difficulty lying down flat. The head cannot touch. The rear of the head cannot touch the surface of the table, so he needs a higher pillow to sit up under his head so he can lay down comfortably.

Q. And you're certain the head did not touch the examining table.

A. Yes, I am certain about it.

This concludes reading portions of Diplomate Deng's testimony of what existed on 7-6-96. Back to questioning Diplomate Felder MD

Q. From the pages I've just read you, Diplomate Felder, does that reinforce your opinion of ankylosing spondylitis on 12-5-96?

A. Yes

Q. And why would that reinforce your opinion?

A. Because again, it brings out the limitation in movement of a patient having ankylosing spondylitis, in my opinion.

Page 48

ln. 12 Q. Diplomate Felder, do you see any evidence of quality control procedures applied to the face of that form (encounter form) by Dr.Mancall or any institution?

A. I can't say that I do, but I'm not exactly sure what that would mean.

Page 49

ln. 4 Q. Okay. Dr.Mancall, in his deposition, has indicated that the first paragraph, the top of that form was written by a medical student who he does not recall the name of the medical student. In your medical opinion, is--would it have been important for him to make sure that the name of the medical student was noted before he signed the bottom of that form?

A. Well, in my opinion, usually the medical student signs and the attending physicians sign.

ln. 19 Q. Would the signing of that or putting a notation by the medical student, would that assist at a future date if the doctor had questions about the completeness of the medical history?

A. Yes, it could.

Page 50

ln. 13 Q. Do you have Dr. Waterman's deposition?

A. Yeah, okay.

Q. On 9-15-99, Dr. Waterman wrote a letter to Dr. Kellman in which he stated that he had treated the patient and that he had taken radiographs and he goes on to say those X-rays reveal that he does have indeed, have a spondylarthropathy, which I had suspected.His x-rays are compatible with a diagnosis of ankylosing spondylitis.

In addition, this type of spondylitis may be secondary to the aforementioned history of inflammatory bowel disease. I spoke with Mr.Maresca on 9-15-99. I told him that he would probably benefit from either a nonsteroidal anti-inflammatory, Indocin or sulfasalizine .

He has been on sulfasalazine in the past for his inflammatory bowel disease & actually tolerated it quite well. I instructed him to get in touch with you since he regards you as his primary care physician.

I feel uncomfortable prescribing medications like this at such a long distance. It would be impractical for him to come to the UCONN in Farmington on a regular basis for monitoring these medications. I also mention the fact that he could, perhaps, be referred to a local rheumatologist who could monitor his care.

The dose of indomethacin that is usually used for spondylarthropathy is 50 milligrams TID.

Sulfasalizine is given in a total dose of approximately two to three grams per day, usually in divided doses, BID.

Both these medications have been shown to be effective in the treatment of inflammatory back disease.

Signed
Dr.John R. Waterman MD
Assistant Professor of Medicine

Admitted Trial Exhibit 94 and 95 of Dr.Waterman Rheumatologist with a finding of Ankylosing Spondylitis at the 9-15-99 measurement date, a description of a great deal of musculoskeletal problems and the need for an inflammatory back pain protocol to deal with inflammation.

And Dr. Kellman has admitted to reading this letter.

Page 51

ln. 23 Q. In your medical opinion Dr. Felder, what is the sulfasalazine accomplishing?

A. I would think decreasing inflammation.

Q. And what would indocin accomplish?

A. It's a nonsteroidal anti-inflammatory agent that would decrease inflammation.

Page 53

ln. 3 Q. Okay. You read the deposition of Dr.John Waterman completely.

A. Yes I have

Q. As well as Exhibits?

A. Yes

ln. 15 Q. And in reading the deposition of John Waterman, is it your medical opinion that that deposition reinforces your belief that the existence of ankylosing spondylitis was in place as of 12-5-96? Does that reinforce your suspicion that it was in place?

Page 54

ln.1-10 A. It is my opinion that would be correct. That at the encounter, the original encounter that you had --someone took my letter--with--let me pull it out here. That on your 12-5-96 visit, you did have, it would be my opinion at that time, point in time, ankylosing spondylitis and symptomatology thereof.

Q. Okay. If you would go to Pg. 24 of Dr.Waterman's deposition , Lines 15 to 22?

A. Yeah

[Diplomate Felder begins to read from Dr. Waterman's deposition.]

Page 54 continued
ln.14 Q. He's talking about the importance of daily exercises.

A. Yes.

Q. Okay. Is it your-would you concur that his conclusion that the patient wasn't doing daily exercises at that point, would you concur that was an important element of the patient's treatment?

A. I would concur with what Dr. Waterman is saying here.

Q. Maybe if you could read what he is saying here.

A. (Diplomate Felder reading) Starting ln.15 p.24

Page 55-6
ln.1 Q. Yes

A. Question, in your examination of the patient, was it obvious to you that the patient was or did you elicit from the patient whether or not he was doing daily exercises, as opposed to periodic exercises?
Answer by Dr. Waterman- I don't think that is noted.
Was it evident that the patient was doing daily exercises? I should say not . (By Dr. Waterman)

A. --when you examined the patient, did you turn the head from left to right? Answer- yes. Did you find a normal range of motion?
Answer- No.
What did you find? Answer, decreased cervical range motion in all directions, both passive and active.

Q. Okay, Diplomate Felder, could you define what decreased cervical range of motion would mean?

A. That would be decreased range of motion in all directions, is what he's saying here, of the neck, of moving your head back and forth, up & down etc.

Page 58

ln. 18 Q. Okay. Diplomate Felder, have you seen this encounter form of Dr. Carter Abel?

A. I believe I have yes.

Q. Okay. And if you'll draw your attention to the top of that form which was prepared 7-28-1999. It preceeds the examination by Dr. Waterman.

Q. Okay. Diplomate Felder, what is on the face of this 7-28-99 encounter form of Diplomate Abel?

A. Exhibit 135

Q. Yes

Page 59

ln.1 A. Says visits, Mr.Joseph Maresca, Bronxville, NY, your date of birth under history and physical. Do you want me to read this or-

Q. Just the first part where it's talking about the iron hand.

A. Oh, feels like, quote, iron hand, end of quote, on scalp pulls upward for more than 3 years duration.

Q. Is that notation consistent with the existence of ankylosing spondylitis?

A. Yes

Q. Why would that be compatible with the existence of ankylosing spondylitis?

A. Because it's showing limitation of movement and greater than 3 years duration.

Page 59 continued

ln. 17 Q. Okay, if you will go down further on the form,there is a notation see rheumatologist to evaluate for autoimmune disease, including blood work-ups. Would you agree with the assessment by Dr. Carter Abel?

A. Yes, I think that's good.

Q. Why is that a reasonable assessment?

A. Because a blood work-up would help give further information on why you're having symptomatology, such as stated in Harrison's Textbook of Medicine,

Page 60 looking at HLA-B27 , for example.

ln. 2 Q Okay. And also attached to that is the blood work showing the SED rate, the sedimentary rate?

A. Yeah

Q. Now , is that a normal SED rate being reported?

A. No, it's elevated. The reference range is 0-30. You had 38.

Q. And , is that indicative of a more profound problem in the body system?

A. It would be indicative of a problem yes.

Q. Okay. And also I'd like to show you Exh.112-114. These are exhibits of Dr.Terraciano and the Exh. of Dr.Joseph DeCarlo. These I believe you have noted in your report, the existence of the Iritis. If you could tell us, what is on those exhibits?

Page 60

ln. 19 A. This is an eye exam saying 5-29-97, showing with a diagnosis of Iritis, the left eye, OS.

Q. And Diplomate Felder, is the existence of iritis in the May 1997 time frame, is that a potential marker for ankylosing spondylitis, in your medical opinion?

A. Yes, it is listed in Harrison's Textbook of Medicine.

Q. And why would that be a marker for ankylosing spondylitis?

A. Well, it could be one of the symptoms that a patient having ankylosing spondylitis could have. Here to quote Page 1950 acute anterior uveitis (iritis) occurs in a least 20% of patients with ankylosing spondylitis.

Page 63

ln. 8 Q. Diplomate Felder, would you kindly summarize the types of difficulties the patient complained of and that, in your neurologic opinion, you felt were indicative of ankylosing spondylitis?

A. Well, the patient yourself had numerous symptoms, rigidity of the head, neck, spine, loss of range of motion, difficulty, for example using a computer, extensive talking has become difficult for you. Oh here, I did say that you developed Iritis on 5-20-97, yeah, I did apparently note that somewhere. That you've had Crohns Disease, it's been exacerbated. You've had tinnitus, which is sounds-a sound of noise in the ears.

Difficulty going over in bed, moving around in bed, I should say. Tying your shoes, putting on socks, trembling of hands, feet, occasional feelings you've stated that your body seems to freeze up.

ln.24 Q. Okay. Diplomate Felder, have you read the Mortality Among Patients With Ankylosing Spondylitis Not Given X-ray Therapy, by E.P. Radford, 9-15-77, Vol.297
Pages 572-576 of the New England Journal of Medicine?

A. Yeah, I did see that [Referenced Trial Exhibit 279]

Page 65

ln. 5 Q. Okay. Back on the record utilizing Civil Rule 803.18, which allows the discussion of scientific journal medical journal type information, given this article Mortality Among Patients With Ankylosing Spondylitis Not Given X-ray therapy, this article mentions that these results of 836 patients with ankylosing spondylitis investigated indicate,at least in men, ankylosing spondylitis has life-threatening consequences related to many
organ systems, consistent with systemic vascular degeneration as one long-term consequence of the disease. In addition, mortality risk relative to the general male population was fourfold for all gastro-intestinal disease, nearly twofold for accidents, suicide & cerebrovascular disease and 40% in excess for other circulatory diseases.

Page 65-66

ln. 22 Q. Dr.Feldman, do you believe that statement in the abstract of the New England Journal of Medicine, a scholarly medical journal, that that abstract would fairly describe the risks of ankylosing spondylitis?

A. In my opinion. Yes

Page 66

ln. 17 Q. Okay. And would you agree that the plaintiff had those types of risks during the period 12-5-96 (the date of Dr.Mancall's exam) to 9-15-99, the date of discovery of the ankylosing spondylitis?

A. Yes.

Bradley Goewert, Esq.-Cross-Examination

Page 81

ln. 8 Q. And now you sit on the Board of Nutra Pharma Corp.?

A. That's right (Diplomate Felder-continued)

Page 84

Ln. 10 Q. All right- and that's you agree, Dr. Felder, that headaches are not a sign or symptom of ankylosing spondylitis?

A.It's my opinion that headaches can be a secondary symptom of ankylosing spondylitis and that the neck is connected to the head, and if a patient has a great deal of cervical neck problems, it can cause possibly headaches.

Page 85

ln. 16 Q. Do you agree that chronic tension headaches was an appropriate diagnosis?

A. Yes, it is a diagnosis of one of Mr.Maresca's symptoms.

Page 110

ln. 20 Q. Would you agree that there's no known medication which has clearly been shown to alter the natural history of the disease?

A. That's correct.

Q. Okay.

A. Its treatment of symptomatology.

Q. You treat symptomatology?

A. Yeah.

Page 114

ln. 21 Q. Under the Civil Rule 803.18, this is a scholarly document, Kelley's Textbook of Rheumatology. It states on page 1049 that overall, the first 10 years of disease is particularly important with respect to subsequent outcome. Dr.Felder or Diplomate Felder would you agree with that statement?

A. Yes. I agree with the statement.

Page 115

Ln. 3 Q. Does your opinion change based upon the cross-examination of Bradley Goewert in terms of writing your letter, what you have heard subsequently, does that change your opinion in terms of the 11-22-02 letter that you wrote?

A. Well, my letter was based upon the documents I was given, and I reviewed them, I spoke with you, and I came to those conclusions.

Q. Have those conclusions changed?

A. I would say I still hold those conclusions.

Q. All right. Based upon the letter given to Dr.Mancall in the 12/96 examination describing the inability to do a sit-up or to run, are those still very important things that have been brought to Dr.Mancall's attention that are pertinent to a diagnosis of ankylosing spondylitis?

A. Well , they would be pertinent.

Trial Exhibit 43

Evidence entered prior to the close of Plaintiff's Case in Chief
Exhibits 43-53

PATIENT DATA-Maresca
THOMAS JEFFERSON UNIVERSITY HOSPITAL
HISTORY PHYSICAL EXAMINATION
PROGRESS NOTES
DEPARTMENT OF NEUROLOGY USE ONLY
12-5-96
cc: Headaches @ 7 mo.
HPI: Headache x 7 mo. duration. HA'S worsen late in day & after typing on computer. Believes these are tension HAs. Pain is non-localized involving entire head. Pain relieved by external pressure to scalp. HA occasionally accompanied by tingling in fingers. HA episodes occur every day & throughout
each day.Has been wearing waist support belt to help c HA symptoms. Believes that pulling in stomach c belt lessens pulling of facial muscles which relieves pain. HA relieved by lying down.
PM Hx: Crohn's Disease- diagnosed '91
L4-L5 disk- diagnosed '91
PSH: Theta symbol
Medications: None
ALL: Penicllin
OE: OBESE BP:140/80
MENTATION-CHECK LANGUAGE-CHECK
Cranial nerves all normal. Fundi check meaning normal.
Motor strength, bulk, tone, check means normal(note obese)
Deep tendon reflexes are 2+, equal Plantars PL-downgoing
Cerebellar function normal. Sensation normal.

Trial Exhibit 43-continued

Diagnosis, chronic tension headache.Rule out intraventricular tumor. Plan MRI, If Okay, Fiorinal, return post-MRI. Signature-Dr. Mancall MD scrawled

Source: Deposition of Dr. Mancall MD 7-24-02 p. 37 ln. 20

Witness: The part that I wrote personally is toward the bottom where it begins OE, standing for on examination. Everything above that I did not record. pp. 37 ln. 9-12

Trial Exhibit 44

Approved by the District Court prior to closing the Plaintiff's Case in Chief

Elliot L. Mancall MD Patient Office: Neurology Outpatient
834 Chestnut St.
Suite 420 Phil. Pa.
Academic Office: Thomas Jefferson University Hospital
Department of Neurology 1025 Walnut St.
Phil. Pa.

Name: Joseph S. Maresca Date: 12-5-96

Rx: MRI head c and s R/O intraventricular mass lesion

Signature: Dr. Elliot L Mancall License # DEA AM 2448240

Trial Exhibit 45
Approved by the Court prior to closing Plaintiff's Case in Chief
2-5-97
Elliot L Mancall MD
Neurology Outpatient Office
834 Chestnut St. Suite 420 Phil. Pa.

Dear Dr. Mancall:
RE: MARESCA, JOSEPH S.
MAGNETIC RESONANCE IMAGING OF THE BRAIN W/CONTRAST:

Imaging sequences consist of spin echo TI weighed sagittal & axial scans obtained pre and post injection of intravenous Galolinium contrast. T1 weighed coronal scans obtained post contrast, T2 weighed axial scans and multiecho coronal scans.

No masses or enhancing lesions demonstrated. There is evidence of cerebellar atrophy. No congenital abnormalities are demonstrated. The inferior border of the cerebellum appears to be just above the cervical occipital junction in satisfactory position. The brainstem is unremarkable in appearance. The auditory nerves appear intact. There is no evidence of edema.

There is no ventricular deformity or ventricular shift. There is no ventricular dilation or cortical atrophy. There is no evidence of an intraventricular lesion. There is no evidence of white matter plaque. There is no evidence of trigeminal neuroma. There is no evidence of other cerebral neoplasm. There is no evidence of cerebral infection. There is no evidence of aneurysm,

arteriovenous malformation, subdural hematoma, subarachnoid hemorrhage, cerebral contusion, cerebral infarct or pituitary
lesion.

IMPRESSION:

1. CEREBELLAR ATROPHY
2. OTHERWISE, NEGATIVE MRI SCAN OF THE BRAIN, OBTAINED PRE and POST CONTRAST.

SPECIFICALLY, THERE IS NO EVIDENCE OF INTRAVENTRICULAR MASS LESION OR OTHER NEOPLASM SUCH AS TRIGEMINAL NEUROMA.

David P. Gerstman MD, Radiologist OPG: ET/ ms
[NYS License 60 086 048 Dix Hills, NY]

Trial Exhibit 46-Approved by Court

Office of Dr. Elliot L. Mancall
Patient Office
Neurology Outpatient Office
834 Chestnut St. Suite 420
Phil. Pa. 19107 STAMPED : FEB. 13, 1997

Attention: Dr.Elliot L. Mancall MD
Regarding: Patient Joseph S. Maresca
Tension headaches, MRI

Sir,

As we discussed, I visited a local general practitioner, Dr. Filannino MD at 718-892-1447 for the follow-up treatment of this condition. He prescribed Imitrex at 25 mg. for a 30 day supply-final. The Imitrex appears to be the Sumatriptan used to constrict blood vessels. This would appear to be the treatment, although it is a powerful medication with side effects. The cost is also significant; however, I'm told that the medication works well in over half the patients-according to the pharmacists I've called.

The Pharmacist has suggested taking a portion of the prescription initially because it is so expensive (circa $380.). Sometimes the medication works well after just several pills. Others on this medication have told me that a few pills usually gives substantial relief and the remainder of the prescription is kept in case of a recurrence. I'm going to try this route unless you have objections with regard to taking the medication at this time.

Sincerely,

Joseph S. Maresca Feb. 9. 1997
Box 646 Bronxville, NY 10708-3602
914-649-3817

Trial Exhibit 47-Approved by Court

Valerie-Please show Dr.Mancall and file in my records

Feb. 15, 1997

Dr.Elliot L.Mancall MD
Neurology Outpatient Clinic Stamped 2-24-97
834 Chestnut St. Suite 420
Phil. Pa. 19107

Regarding: Tension Headaches/MRI/Treatment Imitrex 25mg

Sir,

Previously, we discussed that the MRI disclosed what was believed to be a normal shrinkage of the cerebellum and little else.

My local physician, Dr.Filannino, prescribed the Imitrex at 25 mg. to treat the tension headaches. After a week, I have a much improved circulation in the fingers. That is, I no longer experience the tingling. In addition, the tension in the upper palate of the mouth has reduced significantly. There is still some tension in the forehead which worsens at night.

I've asked Dr.Filannino to increase the dosage to 50 mg.pills. We discussed (he and I) that this option might clear up the remainder of the headache. Otherwise, we may have to try another medication or combination of medications. In addition, I will ask Dr.Filannino whether or not some arteriography might be helpful to highlight the status of the blood vessels in the head and neck.

The Imitrex (Sumatriptan) is sold in doses varying from 25mg.-100 mg. The 25 mg. pills are $12.88 apiece. The 50 mg. pills are $15. each and the 100 mg. pills are $18.50 apiece. Obviously, it is more efficient to upgrade the dosage rather than taking multiple pills at the 25 mg. level. For instance, it's cheaper to take a 50 mg. pill for $15. instead of 2@25 mg. pills costing well over $25. The 50 mg. pill produces a savings of $10 per pill over taking 2 @ 25 mg. pills.

Trial Exhibit 47-continued

I assume that you've examined the original x-rays forwarded to your office. Dr.Gertsman of the MRI group produced the report forwarded to you; however, I'd like to be assured that at least 2 physicians have examined the films in detail and come to the same or similar conclusions. I'm also concerned that the MRI has been taken and interpreted properly.

Sincerely,

Joseph S. Maresca 2-15-97

Box 646 Bronxville NY 10708

Exhibit 48-Approved by Court

Dr.Elliot L.Mancall MD
Neurology Outpatient Office
834 Chestnut St. Suite 420 Phil.Pa, 19107
Regarding: Joseph S. Maresca-Tension Headaches
50 mg. per day Imitrex/Sumatriptan

Sir,

My local physician, Dr. Filannino has increased the dosage;however, there is no permanent relief of this headache except at night when lying down. The Imitrex appears to relieve the tingling in the fingers; however, the tightening of the trigeminal nerve structures continues unabated.

I may need a medication which will liberate the nerve structures.
Perhaps, Haldol, Robaxin or one of the muscle relaxants is the prescription needed to deal effectively with loosening the trigeminal nerve structures which appear to be quite frozen and rigid. I have a small personal acupuncture appliance which delivers som e measured electrical stimulation to the forehead. This breaks up the tension into smaller components. It helps but it is not a permanent solution. At most, the acupuncture translates
a frozen facial mask into smaller pockets of tension evenly distributed from the forehead to the throat.

Kindly consider all of the above and advise me as to which direction might provide a permanent resolution of this headache.

Sincerely,
Joseph S. Maresca, patient
Box 646 Bronxville NY 10708
914-649-3817

Exhibit 49-Approved by Court

Dr. Elliot L Mancall:Hahneman Hospital

Patient: Joseph S. Maresca

Box 646 Bronxville NY 10708-3602

Tel: 914-649-3817

Time frame of last visit: 3rd Q of 1991

Diagnosis: L4 and L5 disk problem

Technique-Coronal T1, sagittal, double echo and T1 as well as axial T1 images were obtained providing good spatial resolution of contrast.

Test Results: The normal lordotic curve is preserved. Degenerative changes of the intervertebral discs with loss of disc height and dissecation is noted at the L4 L5S1 levels. Central bulging of the anulous fibrosis is noted at the L4-5 level without evidence of thecal sac impingement. The epidural fat is preserved . At the L-5 S-1 level herniation of the nucleus pulposus is noted in right paramidline distribution causing

effacement of the thecal sac. This material is noted in the inferior portion of the L5 neural foramen without significant canal stenosis.

Degenerative changes of the intervertebral disk at the L4-L5 and L-5-S1 levels. Central disk bulge at the L4-L5 level. Right paramidline herniation of the nucleus pulpous at the L5-S1 level causing effacement of the thecal sac at that level.

by Luigi Arena MD [NYS License 60 174 471 Yonkers]

by Zelig Weinstein MD [NYS License 60127373 Monsey]

Referred to: Dr. Frederick Simeone MD
Suggestion: Surgery was not recommended after a review of MRIs.
Therapy: Dr. TV Seshan MD 914-347-3884 Physical Medicine and Rehabilitation

Moist head. Cold packs Ultrasound Electrical Stimulation, Lumbar Traction Massage Spinal Extension Program Isometric Exercises and Ergometer at Lower Extremity
Frequency: 3 times a week for 4 months and wearing
Abdominal Binder indefinitely
Acupuncture applied

Effect: Gradually the patient returned to most activities including carrying heavy packages , light exercise, extensive computer terminal operation etc.

There appeared to be some permanent ability to do sit-ups and run at maximum speed. The abdominal binder is a necessity to prevent back pain.

Current Problem: Tension headaches with slight tingling of the fingers after arising from bedrest. These headaches gradually worsen during the day due to rapid keying of the computer keyboard. Areas of investigation-tension headaches, migraine, Probably not a tumor because pain subsides when lying down. Sumatriptan or trigeminal nerve injections

Exhibit 50-Approved by Court

Advanced MRI Imaging
Patient: Joseph S. Maresca DOB 1-14-52 Sex M
Date 8-17-91 MRI Exam-Lumbosacral spine

Order written by Dr. Mancall-Exh. 53

Technique: Coronal T1, sagittal double echo and T1 as well as axial T1 images were obtained providing good spatial resolution of contrast.

Findings: The normal lordotic curve is preserved. Degenerative changes of the intervertebral discs with loss of disc height and
dissection is noted at the L4 L5 and L5 S1 levels. Central bulging of the annulus fibrosis is noted at the L4 L5 level without evidence of thecal sac impingement. The epidural fat is preserved. At the L5S1 level herniation of the nucleus pulposus is noted in right paramidline distribution causing effacement of the thecal sac. This material is noted in the inferior portion of the L5 neural foramen without significant canal stenosis.
IMPRESSION:
Degenerative changes of the intervertebral disc at the L4L5 and L5S1 levels. Central disc bulge at the L4L5 level. Right paramidline herniation of the nucleus pulposus at the L5 S1 level causing effacement of the thecal sac at that level.
by Luigi Arena MD Zelig Weinstein MD
1201 Morris Park Av. Bronx NY 10461

Exhibit 53-Approved by Court

215-246-5010

Elliot L.Mancall MD

Neurology Ambulatory Care Center
1427 Vine St.
Phil. Pa 19102

Hahneman University
Broad and Vine
Phil., Pa. 19102

Name: Joseph Maresca Date 8-15-91

Rx MR entire spine
Dx : ? discogenic disease
chr. cervical and lumbar strain

Dr. Elliot L Mancall MD BNDD NO. AM 244 8240
Signed in script

Exhibit 55-Approved by Court

Neurological Associates at Hahnemann Univ. PC
1427 Vine St. First Floor
Phil. Pa. 19102
Appointments- 215 246 5010
Please Make Checks Payable to Neurological Associates
at Hahnemann Univ. PC

This is your receipt for this amount.

DOCTOR'S NAME: DR.MANCALL GR. 907
JOSEPH S. MARESCA

8-15-91 DATE
CONSULTATION-COMPREHENSIVE $200 FEE
90020
DIAGNOSIS: Chronic cervical and lumbar strain
CASH

Signed
Elliot L Mancall MD Rev. 5/9/91 #1721 form

Trial Exhibit 112-Approved by Court
Joseph S. Maresca
Box 646 Bronxville NY 10708
No Insurance

OD 325 12+ 95
OS 350 100 145

IRITIS O.S.

Al. Sulfate 1%
Maxiline A Oa at nite

Record of 5-20-1997

On 5-25-02 patient given report of medical exam for 5-20-97
Patient has Crohn's history.

Report of Dr. Joseph DeCarlo MD- Opth.

Trial Exhibit 114 -Approved by Court

Case 10634 Maresca, Joseph S.
Box 646 Bronxville NY 10708 5-29-1997
914-649-3817 DOB 1-14-52 Age 45 Sex M

Medical history of Crohn's Disease
L red eye 3 weeks
-3.25 = -1.75 x 180
-350= -1.0 x 45
1 squeeze
deleted pupil Ac Cli KP delta

-3.25 = 20/30 -4.5 20/50
fundi-dise macular OK
Pred Forte 17 OS Q/D
1 bottle Pred Forte 17
11-23-99 OS QID renewed prescription

Pasqual A. Terraciano MD
2241 Esplanade Av. Bx. NY 10469
718-654-7122

Trial Exhibit 135 - Approved by Court
Carter G. Abel MD-Diplomate 201567-5969
Maresca, Joseph S.
Box 646 Bronxville NY 10708-3602 914-649-3817
Referred by Dr. John McCarthy now deceased
Drug Allergies: Penicillan / Pollam
History and Physical Ht. 5" 7 240# BP 135/85
c/o scalp discomfort
o feels like "iron hand on scalp pulls upward--> 3 years duration
o improves after 3-4 hours of resting or sleep
o progresses throughout the day; denies trouble swallowing
REX: NEG for cervical, occipital, axillary, sup adenopathy today
Full Skin Exam: Face, abdomin, back, neck ears, scalp.
Negative for evidence of scleroderma-no plaques or loss of scalp hair or BCC, SCCar HM of this type on exam
Rosacea: Metrogal GID provided
Scalp tightness/Muscular Spasm
o see Rheumatologist to evaluate autoimmune disease including blood work-up for Lupus and other related
o Today there is no physical evidence or symptoms suggesting Raynaud's phenomena or scleroderma
Biopsy of scalp was offered but declined by patient.
Otherwise, no therapy is indicated at this time.

Trial Exhibit 135- Approved by Court--continued
Patient agrees to see Rheumatology and to pursue
blood tests in the near future. Shark Cartilage
MEDS: Intravenous Magnesium, B12, Calcium
Watch diet doesn't drink whole milk
PHH: Crohn's Disease and quiet recently
Oxidative Stress Test and Uses magnetic therapy
Physically active with max.computer 18 hours
Hands are dry and shiny but do not turn purple.
saw neurologist, cervical images reportedly OK
Elliot Mancall (Y/S) Thomas Jefferson Hospital
Ideal weight 160#
Myasthenia Gravis (test) NEG
Thyroid Tests Negative
R/O , if condition warrants it
Initialed : Dr. Carter Abel MD
Note : Trial Exhibit 136 shows paid bill $110 on 7-28-1999
692.70 Diagnosis 98204 Procedural Services

Trial Exhibit 117 - Consideration Taken Under
Advisement by the Trial Court

Dr. Dworkin MD-Surgeon 12-20-91
Ileocecal Valve Rectum

ADEQUATE PATHOLOGY EVALUATION REQUIRES HISTORY

Maresca, Joseph S. 39 years old
Box 646 Bronxville NY 10708

FEVER 1 increased WBC/ ESR
R/O Crohn's Disease , Increased AFB
Infection at Ileocecal Valve Area

D.Dworkin
Surgeon's Signature

Pathological Diagnosis: A) Ileocecal Valve: Ileal and colonic mucosa showing ulceration and granulation tissue with mild focal cryptitis and acute and chronic inflammation. No evidence of granulomata

B) Rectum (Biopsy) Colonic mucosa with focal lymphoid aggregates. No evidence of cryptitis-cryptal granlomata
The specimen is received in formalin in two parts.

Part A labelled Ileocical valve biopsy x 7" are 7 fragments of soft tannish tissue measuring in aggregate .8 x .2 x .2 cm. All tissue issued in cassette. B

Summary of Specimen A) B) Entire specimen
12-23-1991 R. Abbi, MD Pathologist Signature
[Note: Trial Exhibit 116 Sulfasalizine 1/2 gm. 3 times renew]

Trial Exhibit 279- Read by Diplomate Felder MD at Trial

Mortality among patients with ankylosing spondylitis not given x-ray treatment Vol. 297:572-577 9-15-1977
Vol.11 by EP Radford, R. Doll and PG Smith

ABSTRACT
We investigated age-specific mortality rates of 836 patients with ankylosing spondylitis diagnosed during 1935-1957. These patients were not given deep x-ray therapy, and thus their mortality was not confounded by possible late effects of radiation.
Follow-up observation was to 1-1-1968--on the average over 13 years from enrollment. Men had higher mortality than women; excess mortality was observed in men for diseases known to be associated with spondylitis, such as ulcerative colitis, nephritis and tuberculosis or other respiratory disease. In addition, their mortality rate relative to the general male population was fourfold for all gastrointestinal disease, nearly twofold for accidents, suicide and cerebrovascular disease and 40 percent in excess for other circulatory diseases. These results indicate that
at least in men, ankylosing spondylitis has life-threatening consequences related to many organ systems , consistent with systemic vascular degeneration as one long-term consequence of the disease.
THIS ARTICLE HAS BEEN CITED BY OTHER ARTICLES:
o Vildirir A. Aksoyek, Calguneri, M Aytemir, K. Kabakci, G. Ovune , K.

Expert Letter of Diplomate Felder MD for the Plaintiff
part A.76-79 of the Appellate 3rd Circuit Appendix
Faxed to Judge Legrome Davis and read into the
Trial Testimony of Diplomate Felder MD 1-16-04

Mitchell S. Felder MD
Board Certified in Neurology

Diplomate of American Board
of Psychiatry and Neurology

Suite 2
87 Stambaugh Av

Sharon Pa. 16146

November 22, 2002
RE: Joseph S. Maresca
Dear Sir/Madam,
I reviewed the medical records of Mr. Joseph S. Maresca and my medical and neurologic conclusions are based upon these records.

The records consist of: (1) deposition of Elliot Mancall, (2) deposition of Diplomate Deng 3) deposition of John Waterman MD and Exhibits

In summary, Joseph S. Maresca is a 50 year old male, DOB 1-14-52 , who on 12-5-96 had a visit at Dr. Elliot Mancall's office. At that point in time, the patient was complaining of significant headaches and lumbosacral rigidity. The visit took place at the Thomas Jefferson University Hospital. At the time of the visit, the patient could not do a sit-up or run.The patient had a history of Crohns disease over 5 years prior to the visit.

The patient was also complaining of progressive neck stiffness and stiffness of the facial and scalp muscles. Above Dr.Mancall's writing, an unknown person from Thomas Jefferson University Hospital noted that this patient had headaches of 7 months duration. The headaches worsened later in the day after typing or working on the computer.

Under the C.S. Par 6101-4 Sec 115.32 (e)
"A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry shall be individually authenticated. "
In addition, C.S. Paragraph 6101-4 Sec 115.33b of the Penn. Code deals with medical records. It reads as follows:
"Entries in the record shall be dated and authenticated by the person making the entry."

As per the deposition of Elliot Mancall, MD pages 12-20, the patient's head movements were not examined nor was there an examination of the spine, recollection of the patient's position while lying flat on the examining table, any deficiency of neck posture, evaluation of the pelvic area, examinations of rotations of the thigh, or recollection of difficulty in the patient getting off the table. Dr.Mancall's notations on the 12-5-96 medical records showed cranial nerves 2-12 to be intact, fundi to be within normal limits, motor strength muscle tone were found to be within normal limits, deep tendon reflexes were found to be 2+ symmetrically equal, planar response was flexor, cerebellar function was within normal limits.

The patient was actually given a diagnosis of Chronic Tension Headaches when the disease process present was Ankylosing Spondylitis in all likelihood. Mr.Maresca reportedly demonstrated a number of physical limitations to Dr.Mancall and a medical student who was in the office. However, this information was not reportedly recorded such as the fact that the patient had kyphosis where there was forward leaning of the spine approximately 15 degrees, and inability to do a sit-up, and the fact that the patient's head could not touch the wall while standing adjacent to the structure. Mr.Maresca had subsequently sent Dr.Mancall three (3) memos. Dr.Mancall did not answer or follow-up on the memos, and that follow-up probably would have lead to further investigation of this patient's condition. In the 2-13-97 memo to Dr.Mancall the patient related the fact that he was taking Imitrex. In a 2-24-97 memo, the patient was complaining of "some tension in the forehead which worsens at night". In a 2-26-97 memo, the patient complained to Dr.Mancall that the "tightening of the trigeminal nerve structures continued unabated". The patient was subsequently correctly diagnosed at UCONN Medical Group by John R. Waterman, MD, the Assistant Professor of Medicine. On 9-9-1999, the patient has a cervical spine with oblique views showing evidence of ossification of the anterior longitudinal ligament with bridging syndesmophytes and a suggestion of multi-lateral facet fusion with an impression of multi-level facet fusion

and a differential diagnosis of Ankylosing Spondylitis.On 9-9-1999, the patient had a lumbosacral spine which was AP and lateral showing multilevel facet overgrowth and calcifications of the infraspinous ligaments and fusion of the sacroiliac joints with an impression of multilevel syndesmophytes and ossification.

It is my medical and neurologic opinion that Mr. Joseph S. Maresca should have been ruled out for having ankylosing spondylitis at his visit with Dr. Elliot Mancall. This patient showed multiple features of a classical ankylosing spondylitis (AS Syndrome). As per Harrison's Principles of Internal Medicine , 15th Edition, "the inflammatory back pain of AS is usually distinguished by the following 5 features: (1) age of onset below 40 (2) insidious onset 3) duration greater than 3 months before medical attention is sought, (4) morning stiffness and 5) improvement with exercise or activity. Mr.Maresca fits all of these criteria. A diagnosis could have been achieved also by looking at the histocompatibility antigen HLA-B27.It must also be noted that AS is strongly associated with Inflammatory Bowel Disease both ulcerative colitis and Crohn's Disease. The fact that Mr.Maresca had a history of Crohn's Disease at the time of his original visit with Dr.Mancall would also help to rule out ankylosing spondylitis in the differential diagnosis for this patient.

In my medical and neurological opinion that the standard of care at the visit on 12-5-96 at Dr.Mancall's office was not appropriate for this patient's condition. Computed tomography and magnetic resonance imaging (MRI) are able to detect abnormalities at an early stage of ankylosing spondylitis, in fact, earlier than with plain radiography.

As per Harrison's Textbook of Medicine, it is noted that MRI has emerged as a highly sensitive and specific technique for identifying early intraarticular inflammation, cartilage changes, and underlying bone marrow edema in sacroilitis (Harrison's Principles of Internal Medicine, 15th Edition, page 1951)

During the 12-5-96 visit, Dr. Mancall ordered and the patient completed an MRI of the brain. The patient required a roentgenogram or MRI of the back. The need for a roentgenogram of the back was recognized, the order was written and the results were finally discussed with the patient by Dr.John Waterman on 9-15-99.

Another possible method for diagnosing this patient would be utilizing the New York Criteria (1984) which are widely used for diagnosis of this condition. This consists of (1) a history of inflammatory back pain, 2) limitation of motion of the lumbar spine in both the sagittal and frontal planes, 3) limited chest expansion relative values for age and sex and 4) definite radiographic sacroilitis plus any one of the other 3 criteria is sufficient for diagnosis of definite ankylosing spondylitis (Harrison's Principles of Internal Medicine, 15th Edition page 1951).

At the visit at Dr.Mancall's office 12-5-96, the Schober test would have been a useful measure for ankylosing spondylitis. This is a test in which the patient stands erect with heels

together and marks are made directly over the spine five (5) centimeters below and ten (10) centimeters above the lumbosacro junction. The patient then bends forward maximally and the distance between the two marks is measured. The distance between the two marks increases five (5) centimeters or more in the case of normal mobility and less than four (4) centimeters in the case of decreased mobility (Harrison's Principles of Internal Medicine, 15th Edition page 1950)

Mr.Maresca has stated that he suffered numerous difficulties secondary to the non-diagnosis of his condition. Namely, 1) continuing rigidity of the head, neck and spine and restriction of torque movements, 2) loss of range of motion 3)keying on the computer was downgraded and began to involve incrementally more pain 4) extensive talking/lecturing became more difficult for him , 5)difficulty with diaphoresis, 6) the patient develops iritis 5-20-97, 7) Crohn's Disease was reportedly aggravated, 8) the patient had tinnitus bilaterally with a hissing sensation, 9) the patient found turning in bed more difficult, 10) patient has difficulty turning book pages 11) the patient has had difficulty operating instruments ; such as a keyboard 12) patient has difficulty tying his shoes and putting on socks, 13) patient is unable to do a sit-up or get up from an examining table unassisted, 14) the patient has trembling in his hands and fingers and 15) the patient ocassionally states he has entire body freezing.

It is my medic[illegible]d neurologic opinion that these difficulties related to his u[illegible]gnosed condition Ankylosing Spondylitis in all likelihood.

As per the Harrison's Principles of Internal Medicine, 15th Edition, page 952, it is stated that with ankylosing spondylitis "participation by the patient in an exercise program that is designed to maintain functional posture and to preserve range of motion. There is evidence that exercise increases mobility and improves function. The proportion of patients with severe deformity has decreased markedly in recent decades, probably because of earlier diagnosis and widespread use of physical therapy." It also stated that "the peripheral arthritis may also respond to the folic acid antagonist methotrexate." Harrison's Principles of Internal Medicine, 15th Edition, pager 952, stated other possibilities for paliative treatment which would be intralesional or intraarticular glucorticoid injections and CT guided glucorticoid injections into the sacroiliac joints.

It is my medical and neurologic opinion that Mr.Maresca has had an exacerbation of his condition due to the lack of treatment of his condition Ankylosing Spondylitis. This increased his symptomatology by approximately 50% over the 3 years prior to when he was properly diagnosed. It is my medical and neurological opinion that Mr.Maresca had ankylosing spondylitis of his original 12-5-96 appointment with Dr.Mancall.

There should also have been follow-up visits by Mr.Maresca arranged by Thomas Jefferson University Hospital.

The lack of follow up by the Thomas Jefferson University Hospital considerably increased the chances that the condition Ankylosing Spondylitis went undiagnosed and substantially untreated. The hospital had a non-delegable duty to the patient to ensure that its policies, procedures and standards operated to deliver the medical diagnostic and treatment services requisite to identifying and treating the disease Ankylosing Spondylitis.

In the case of Joseph S. Maresca, these visits probably would have lead to an earlier discovery of his condition because the patient was providing quality feedback on range of motion issues pertinent to the diagnosis.

Philadelphia, Pennsylvania , in my medical opinion typically has one of the highest standards of care in the U.S. In my medical and neurologic opinion, Dr.Mancall, as a neurologist, should have been able to diagnose AS, as noted in the above criteria.

I hope that this letter is of benefit to you in your continuing evaluation of Mr.Joseph S. Maresca. Please feel free to call me should you have any queries concerning this medical report.

Yours truly

s/ Mitchell S. Felder MD, Board Certified Neurology

Diplomate American Board of Psychiatry and Neurology

IN THE UNITED STATES DISTRICT COURT FOR
EASTERN DISTRICT OF PENNSYLVANIA
JOSEPH S. MARESCA CIVIL ACTION
v.
ELLIOT L. MANCALL, MD, et al. NO. 01-5355
Philadelphia , Pennsylvania
May 4, 2004

BEFORE: HONORABLE LEGROME D. DAVIS, JR.

TRIAL EXCERPT-TESTIMONY OF DR. LEE MD, PHD.
NEW YORK MEDICAL COLLEGE 6/1998 PHYSICAL
MEDICINE AND REHABILITATION
AMERICAN BOARD OF MEDICINE/REHABILITATION
TREATING PHYSIATRIST
8-20-02 DEPOSITION READ AT TRIAL

APPEARANCES:
FOR PLAINTIFF: JOSEPH S. MARESCA, PRO-SE
BOX 646 BRONXVILLE, NY 10708

FOR DR.MANCALL: BRADLEY GOEWERT,ESQ.
1845 WALNUT ST.
PHIL. PA. 19103

FOR THOMAS JEFFERSON UNIVERSITY HOSPITAL: DOROTHY DUFFY, ESQ.
O'BRIEN AND RYAN
HICKORY POINTE
2250 HICKORY ROAD
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PLYMOUTH MEETING
PA. 19462-1065

COURTROOM DEPUTY: MARCELLA EL SHABAZZ

The morning of 5-5-04, Messrs. Maresca (Plaintiff), Goewert, Esq. and Duffy Esq. took turns reading excerpts from Dr. Lee MD's testimony . The testimony was read verbatim before The Honorable Legrome Davis, his deputy, the Court Reporter & jury. The Honorable Davis ruled on entering each excerpt into the record the morning of 5-5-04 before the jury entered the room. Once the jury entered, the parties read the following approved excerpts:

BY THE PLAINTIFF-JOSEPH S. MARESCA

Page 4-5

ln. 20 Q. All right. Dr.Lee, if you will go over, just give us an overview of on 8-14-01 what you did in our first meeting.

A. (Witness-Dr. Simon Lee MD, PhD) Yeah. 8-14-01 I saw Mr. Maresca, and he presented some x-rays, actually at that time was referred by Dr.Deng. And I saw Mr. Maresca and I reviewed the x-ray, and I provided a Schober test for Mr. Maresca, then some general physical examination.

And then the Schober test would show that the two centimeter changes which was below the normal number, which gave a diagnostic value for the ankylosing spondylitis for cervical spine, lumbar lumber spine. And then I referred Mr.Maresca back to continue the acupuncture therapy and home exercise program. Yeah, that's all in the first visit.

Page 7- line 13-21 (Dr.Lee MD PhD took a comparison x-ray of 8/2001 to 9/9/ 99 Dr.Waterman's x-ray)

Q. But when this says there is no interval change, does that indicate to you that the disease process is stable or dormant?

A. Based on my experience yes.

Q. In combination with the Schober test, because you've done a measurement from 2001, and a measurement just about three weeks ago, the Schober was your finding two centimeters?

A. Yes

Page 8 Q. Well, if I do extensive computer keying and that aggravates the disease process, should I do an occupation that does not involve extensive computer keying?

A. Yes

Page 10 Line 7-16 Objection sustained by Judge Davis

The plaintiff asks that the Supreme Court over-rule this objection and enter these lines into testimony because they shed light on the disease process and provide the Court with useful information from an authoritative source.

Q. Also with this disease, ankylosing spondylitis, do you accept the premise that early diagnosis is very important?

A. Yes

Q. And also, is continuity of care important?

A. Yes

Allowed Testimony
Page 10 ln. 17-19

Q. And also, is daily exercise important as opposed to exercising every week?

A. Yes

Page 12 ln. 9-21

Cross Examination -Bv Mr. Goewert, Esq.

Q. Dr. Lee, my name is Brad Goewert. We just met when I came into the room. I represent Dr.Mancall, who has been sued by Joseph S. Maresca.
My question to you is this, when do you normally make a notation of information as part of your medical record?

A. Right after the exam, that day. And I rewrite it.

Q. And when would you re-write it?

A. Like about two weeks ago, just because they needed a formal medical record.

(There was a request for medical information from the defendants to Dr. Lee MD, PhD and he summarized highlights of his examination due to the formal request. This was done without the plaintiff's knowledge but received by the defendants.)

Page 13 ln. 6-10 and ln. 19-21 Pg.14 ln 1-20 continued cross-examination.

Q. And Mr.Maresca had provided as an exhibit in my client's Dr.Mancall's deposition, a report dated 8-14-01, and I show you that here. I think it was previously marked Exhibit 13

A. Right

Q. Would you please show me in the original medical file that you have with you today where a copy of that record would be.

Page 14 ln. 1-20 (Goewert, Esq.)

A. Should be in the chart. It's not there.
Q. Then you also have contained within the chart that's here with you today--
A. Right.
Q. --a handwritten note. Is that your handwriting?
A. Yeah, that's my handwriting.
Q. We'll mark that as Defendant's Exh. 1 or 2 whichever is the first one. We'll mark that two.
A. Right.
Q. Now, when would that record, that handwritten note of August 14 of 2001 have been written?
A. That's about two-four weeks ago.
Q. About August 7th or so, 2002?
A. Right.
Q. So approximately a year after the exam took place?
Q. Based on the theory no. Because I thought they would ask for this record for case purposes.

Page 17 ln. 5-13 (Goewert, Esq.)

Q. Is it your normal practice to create handwritten notes of exams approximately a year after they occur?
A. It's not create (creating something), because we just thought, to make it more formal, I mean, for anyone who wanted to look at the exam.
Q. Did you write this when Mr.Maresca came back 7-21-02?
A. Yes

Page 18 ln. 3-21 and Page 19 ln. 1-7

Q. My question is very simple. Was the note on 8-14-01, which is the long, handwritten note--
A. Right.

Q. --made when you saw Mr.Maresca on 7-21-02?
A. Yes
Q. Okay. Now the information contained within that note of 8-14-01 is supposed to represent your findings and information that occurred back on August 14 , 01 right?
A. Right
Q. Did you record any other information contemporaneous with that visit on 8-14-01, other than the four line hand-written note, which is Defendant's Exhibit
A. Usually, we make a quick note during the visit, and than after that we may complete the note. But at that time, somehow we didn't do it.
Q. So you didn't make any note other than contemporaneous with the visit on 8-14-01, you didn't make any other note other than that one that's Defendant's Exhibit 1, correct?
A. Right.
Q. Do you have an independent memory of the patient's physicalfindings as they would have existed back on 8-14-01
A. Yes

Page 21 ln. 6-11 (Goewert) ln. 16onward -Plaintiff's request

A. Okay. So the reason why I rewrote the record is I thought that it should go for a formal like deposition or whatever, somebody will ask for the record. I didn't you know append any basic information compared to my brief note of that visit.

Q. Right.

A. The basic thing is the x-ray, there's no change. It's a clear cut you know evidence of ankylosing spondylitis in the cervical spine and lumbar spine. And the Schober test was two centimeters based on my examination.

Page 22 ln. 5-19 (Goewert, Esq.)

Q. And my question is, where did you get that information from, that's part of the physical exam that you wrote in 8/2002 for a visit on 8-14-01.

A. By my memory.

Q. Had you ever seen Mr.Maresca prior to 8-14-01?

A. He comes in for acupuncture. We saw him, you know, every week.
We just, because at that time he was treating with Dr. Deng. And then we just talked casual conversation. And also, I checked him (the patient) from time to time, but we didn't have an official patient care relationship yet. I do , you know, see him for a long time--for months.

Q. When?

A. I mean, since early 2001.

Page 23 ln. 1-2 and ln. 8-18

Q. Right. My question, though , was prior to Aug.14 of 2001, did you see Mr.Maresca?

A. Right.

A. I saw him in the treatment room. But, it's not like a doctor/ patient relationship.

Q. Fair enough. And that was in 2001?

A. Right

Q. Now, did you see him at all prior to 2001?

A. I don't remember.

Q. Did you ever see him back in 1996? Did you obtain a history or receive information from Mr.Maresca, a detailed history, about his medical condition, prior to the visit you saw him.

A. No

Page 24 ln. 7-20

Q. Dr.Lee, as part of your initial exam, you take a history of the patient; is that correct?

A. Yes.

Q. Did you obtain a detailed history from Mr.Maresca regarding his medical condition prior to the period of time which you saw him; is that right?

A. I didn't

Q. Is that right?

A. Yes

Q. You also did not obtain copies of some or all of Mr.Maresca's prior medical records; is that true?

A. No

Page 25 ln. 13-21

Q. That's part of my question. It's very simple. You saw him on August 14, 2001.

A. Right

Q. And prior to that, there is a series of x-rays that were done at Central Imaging Associates dated 8-8-2001.

A. I remember, because at that time Dr.Deng asked me, he said he is unable to write an order for an x-ray. He consulted me - this patient needs an x-ray at that time. Yeah, I wrote an order for an x-ray for Mr. Maresca.

Page 27 ln. 1-11

A. I saw him-

Q. Did you see him as a patient prior to that period of time?

A. I didn't write any note at that time.

Q. Was he a patient prior to that? Did you see him as a patient before you wrote an order for the x-ray?

A. At that time, no. I went to write an order as I tried to cooperate with Dr.Deng's treatment because he didn't officially refer the patient for my treatment.

Page 28 ln. 2-9 and Plaintiff ln. 12,13

Q. Did you review the x-rays themselves?

A. Yes

Q. Do you have any training or specialty in radiology?

A. No

Q. How many patients do you have that have been diagnosed with ankylosing spondylitis?

A. Two or three. Couple of them.

Page 30 ln. 1-13 and Page 32 ln. 10

Q. I apologize for this, and I know you gave me an answer, but she didn't get it down on the record. So I need to make sure that there's a record of one of the previous questions.

Which is, is it your testimony that you had approximately a couple of patients that you had in practice over the past six years.

A. Right.

Q. With the diagnosis of ankylosing spondylitis?

A. Correct

Q. Would you consider Dr.Deng as an acupuncturist to be a primary care physician, as you understand the term?

A. Yes.

Page 33 ln. 10-17

Q. Now did you look at those films side by side yourself, the 1999 film and the 2001 film?

A. Yes.

Q. When you reviewed those films, did you have the radiologist's interpretation of those films?

A. Yes. Again, I cannot make any official conclusion out of the film. I just review it because I'm not the radiologist.

Page 34 ln. 2-21

Q. Right. Well, what do you mean you can't make an official conclusion?

A. Usually, the diagnosis should be made by the radiologist. I can agree or disagree with the conclusion. But I cannot draw the conclusion.

Q. All right. You, based on your experience, cannot draw a conclusion about what that x-ray film says--

Q. You mean

Q. Let me ask that question again.

Q. What do you mean when you're saying you can't make a conclusion, an official conclusion, about that x-ray.

A. I mean, I cannot like write a conclusion or like a formal deposition in a court activity, things like that. I can write out what I think.

Q. So you don't think that you would be qualified to make that ultimate conclusion; is that right?

A. Yes

Page 36 ln. 6-16

Q. Do you know who he works for? (meaning Mr.Maresca)

A. No (Dr. Lee MD)

Q. Do you know what his job duties and descriptions are?

A. No

Q. You would certainly not say that Mr.Maresca cannot work is that correct?

A. No. He has a lot of disabilities. I mean , based upon my opinion, he may qualify for the disability.

Page 37 ln. 12-17

Q. Now, the next time you saw him was 7-21-02?

A. Yes.

Q. And, you didn't see anything, any change in his condition from the previous visit? Is that fair?

A. Basically, the same-right.

Page 39 ln. 1-10 and 18-19

Q. All right. Did you see Mr.Maresca prior to 2001? In 2000 or prior to that.

A. No.

Q. So you don't know what his condition would have been in 2000.

A. No.

Q.--or prior to that?

A. No

Q. Is that correct?

A. Right.

Q. Are you aware that Mr.Maresca does karate?

A. No

Page 40 ln. 14-21 by Plaintiff

Q. Also, Dr.Lee MD are you a doctor of physical medicine?

A. Yes

Q. And registered in this state?

A. Yes

Q. And also you have a PhD

A. Yes- in Anatomy, Cellular Biology

Q. Have you ever seen this record before, Charles Deng's record.

A. I saw Dr. Deng's record.

Q. Okay. Focusing on this specific area, he's talking about pain and stiffness in the head, neck and shoulder area.

A. Yes

Q. And the date of this record is 1996. If you would take a look 7-6-1996.

A. Yes.

Page 42 ln. 4-17 Plaintiff over-ruled but request Supreme Court to review and over-rule this objection to form

Q. Okay. To you, Dr.Lee , does the pain and stiffness in the head, neck and shoulder have any meaning in terms of the foundation of ankylosing spondylitis?

A. Yes

Q. It does. How does that relate to ankylosing spondylitis?
A. Patient will feel stiffness and pain, because, you know, because cannot move their joint and spine, you know. And it may cause muscle tightness, what we call muscle spasm or pain.
Page 43 ln. 5-10 Plaintiff over-ruled but request Supreme Court to review and over-rule this objection to form.
Q. Okay. When he says that there is pain and stiffness in the head, neck and shoulders, is he qualified to make that statement?
A. Yes . (By Dr. Lee MD, PhD)
Page 43 ln. 19-21 and Page 44 ln. 1-4
Q. What's the relationship between you, Dr.Lee and Deng.
A. He's a physician treating patients here.
Q. Are you in practice together?
A. No. This is a multi-, you know discipline practice office. We have a physiatrist, we have acupuncture, we have a dentist , we have an internist.

Trial Exhibit 97

During the Plaintiff Case in Chief the Court took Exh 97-100 under advisement. The United States Supreme Court is asked to admit these exhibits into evidence. Defendants did not object when these Exhibits were offered.

Lee and Kong Physicians Patient: Maresca, Joseph S

8-14-01 Xray: L/S no changes comparison in study 2 yr. ago
DTD @B hip. sacroilitis:
C/S Ankylosing Spondylitis
Schobers : 2 centimeters

Script signature: S. LEE

Trial Exhibit 98

Central Imaging Associates Aug. 9, 2001
1234 Central Park Av. Yonkers NY 10704 9147931234
RE: Maresca, Joseph S
PT# CIA 26951
Dte.Exam 8-8-2001

Simon Lee MD
254 Canal St. Suite 4008
NY NY 10013 currently at 81 Elizabeth St.

CERVICAL SPINE:
HISTORY: Ankylosing Spondylitis
AP, lateral, and both oblique views were obtained & comparison to 9-9-1999. There is no interval change. Extensive ossification of the anterior longitudinal ligament is again noted with bridging syndesmophte s. Multilevel facet fusion is again noted. There is no radiographic evidence of foraminal stenosis. Disc space height is maintained. The prevertebral soft tissues are unremarkable.
IMPRESSION: Findings again are most consistent with ankylosing spondylitis. Differential diagnosis includes other seronegative spondylarthropathies.

LUMBOSACRAL SPINE

HISTORY: Ankylosing Spondylitis
AP Lateral and a coned down lateral view of L5S1 obtained. A comparison is made to 9-9-1999. There is no interval change.Again seen ossification of anterior & longitudinal ligament w/ bridging syndesmophytes noted. Disc space height maintained.There is multilevel facet arthritis & overgrowth.

There is normal vertebral alignment.

IMPRESSION: No interval change since the last study. Findings consistent with anky.spondylitis or seronegative spondylarthropathy. Multilevel facet arthritis.

Trial Exhibit 99

Central Imaging Associates
1234 Central Park Av.
Yonkers NY 10704 914793 1234

Aug 9, 2001
RE: Maresca, Joseph S

PELVIS
HISTORY: Ankylosing Spondylitis
A single AP view of the pelvis was obtained . There is fusion of the sacroiliac joint symmetrically. This is unchanged since the prior limbar spine series of 9-9-1999. There is mild degenerative change of both hip joints
manifested by subchondral sclerosis along the acetabular roofs. The symphysis pubis is unremarkable.
IMPRESSION: Degenerative changes of both hip joints.
Bilateral sacroilitis and fusion.
Thank you for referring this patient.

Blumberg MD

R: 10908\ T: 011008\10-11

Exhibit 100

Chinatown Specialty Physicians Aug 19, 2002 2:53 PM
Lee & Kong Physicians PC Patient: Maresca, Joseph S

7-21-02 : His condition is maintained at the same level as the previous visit, Receiving acupuncture 1-2times/week.
PE: AA0x3 Schober's Test: 2 centimeters (delta).
Impression: Patient's condition is similar as previous exam based on the Schober's test.
Plan: Continue current management

Signed

SLEE (script)

Expert Letter of Diplomate Epstein MD-Rheumatologist
Appellate 3rd Circuit Appendix

Pennsylvania Rheumatology Associates, PC
Pennsylvania Hospital
Section of Rheumatology
Barry Schimmer MD, FACP, FACR
Chief of Section Alan L. Epstein FACP, FACR

OFFICE NOTES
MARESCA, JOSEPH S.
10-11-02

Joseph Maresca was seen in consultation on 10-11-2002. The patient is a 50-year old white male who consulted Dr. Elliott Mancall in August 1991 due to difficulty getting up from a chair caused by pain in the lower to mid-back. An MRI scan is reported to have shown degenerative disc disease. The patient was seen by a physiatrist and a physical therapist, which helped considerably. Following formal physical therapy, the patient routinely participated in a home exercise program which controlled his symptoms. At about the same time the patient was known to have low grade fevers. He was evaluated at the Massachusetts General Hospital and Crohn's disease was suspected. The patient was referred for a colonoscopy which confirmed the diagnosis. The patient was treated with a 6 month course of Azulfidine and dietary changes. He did reasonably well from 1992 to 1995.

In late 1995, he noted stiffness in his neck with inability to touch his occiput to the wall. In 1996, stiffness persisted along with tingling in the forehead and a sensation of pulling upwards in the forehead. Six weeks of acupuncture was beneficial. The patient started karate in the hope of helping himself. Due to an inadequate improvement, he again consulted Dr. Mancall. His complaints at the time were an inability to perform sit-ups, the inability to extend his neck and the persistent pulling in the forehead. Dr.Mancall focused on his complaint of the headache. A muscle relaxant was recommended to be prescribed by his local physician.The patient reports that no attention was paid to spinal issues.His local physician prescribed Imitrex without much benefit. Chiropractic therapy was also of limited benefit. From 1996-1999 , the pulling in his forehead worsened., especially when using a computer keyboard or doing intense paperwork. The patient also noted stiffness in his head, upper chest and upper back. His head began bending forward more. Rotation of the torso became more difficult.The patient was concerned about scleroderma. He consulted a dermatologist who excluded this possibility.

A rheumatologist was recommended and the patient consulted Dr. John R. Waterman MD at the UCONN. X-rays of the cervical spine, performed in 9/1999,

revealed ossification of the anterior longitudinal ligament and findings consistent with multi-facet fusion. X-rays of the lumbar spine also revealed ossification of the anterior longitudinal ligament with evidence of extensive syndesmophyte formation. There was fusion of the sacroiliac joints. The patient was felt to have ankylosing spondylitis, likely related to his underlying inflammatory bowel disease.

The patient was referred back to his local physician for treatment with either Indocin or Azulfidine. He apparently did not receive either of these medications, however. He recalls receiving an intravenous infusion and dietary changes were recommended. The patient began feeling better in six months. He has been stable over the past 2 years. His upper extremities are fine. His neck is stiff, and it is difficult to move his head, but there is no pain. His mid-back feels tight. There is no mid-back pain however. The patient also denies any pain in his lower back. His shoulders and hips were fine. He is unable to bend to tie his shoes.He has difficulty putting on socks. He also has difficulty turning while he is driving. ROS: An extensive review of systems is non-contributory. PAST MEDICAL HISTORY: Past medical history is significant for Crohn's disease, lumbar disc disease, ankylosing spondylitis and one episode of Iritis. MED/ALLERGIES: The patient is currently taking only Glucosamine/Chondroitin supplements. He is allergic to penicillin.

SOCIAL HISTORY: He is single and works as an accounting systems. He does not smoke or drink.
FAMILY HISTORY: Is non-contributory.
EXAM: On physical examination blood pressure was 160/80. The skin was clear. HEENT examination was unremarkable. Examination of the neck revealed severe restriction in range of motion with an occiput to wall distance of 10 cm. Chest expansion was reduced as well. Examination of the back did not reveal sacroiliac tenderness. Lumbar motion was reduced with a modified Schober test of 2 cm. Lungs were clear and cardiac examination was normal. The abdomen was benign and without hepatosplenomegaly. On musculoskeletal examination, there was no synovitis. There was no edema. There were no sensory or motor deficits in the lower extremities.

IMPRESSIONS/PLAN:
The patient's symptoms of ankylosing spondylitis, outlined above, date the onset of his illness to 1995-1996. In reviewing the Jefferson Hospital records from 12-1996, there are no complaints recorded that would suggest a diagnosis of ankylosing spondylitis. Specifically, there is no mention in the history of neck stiffness and limited range of motion. The focus during the Dec. 1996 evaluation would appear to have been limited to headaches, felt to be muscular in etiology.

Treatment for ankylosing spondylitis should always include an exercise program to maintain range of motion and improved function. There is no solid evidence, however, that any medication actually improves the natural history of this illness.

Alan L. Epstein, MD
Assistant Clinical Professor of Medicine
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ALE: MT #34

Discussion of Questions Presented

1. Did the District Court and Appellate 3rd Circuit err in awarding the Defendants the Motion as a Matter of Law despite the fact that the plaintiff offered testimonial and documentary evidence that Dr. Mancall's 12-5-96 exam, mis-diagnosis, non-monitoring and lack of treatment was a substantial factor in the increased risk of harm to the patient/plaintiff and that his attachment to the Jefferson Medical College places him in the Thomas Jefferson University Hospital by his testimony, the fact that the logo of the Hospital is on the encounter form and the Jefferson Medical College belongs to the Thomas Jefferson University Hospital, Inc. registered to the Secretary of State.

> "Accordingly, if a plaintiff has proven that the physician's breach increased the risk of harm, then there is sufficient evidence to overcome a motion for judgment as a matter of law. The expert, in cases of this nature has been permitted to testify under the relaxed degree of certainty enunciated in Sec. 323a of the Restatement (Second) of Torts, that the defendant's failure to exercise reasonable care in the diagnosis and treatment was a substantial factor that increased the risk of harm." Eaddy 694 A 2d at 642 citing Billman 761 A. 2nd at 1212-1213.
>
> [5-7-04 decision of the Honorable Judge Davis]

> " The OIG believes that a hospital's written policies and procedures should take into consideration the regular exposure for each function or department of the hospital. Consequently, we recommend that the independent policies and procedures be coordinated with the appropriate training and education programs with an emphasis on areas of special interest by the OIG through its audit function, The OIG concurs: "risk areas include teaching physicians & resident requirements for Teaching Hospitals. "
>
> FR Vol. 63 #35 MONDAY 2-23-1998 P. 8990

2. The Court is asked to establish whether or not the current Pennsylvania Medical Malpractice law in its implementation and interpretation by the Pennsylvania Court System provides a uniform and fair method of determining causal connection of plaintiff's harm to the defendant's breaches and causal relationships for evidentiary purposes at the conclusion of the Plaintiff's Case in Chief and by extension to the Defendant's Case in Chief and the subsequent instruction by the Trial judge to a jury of peers.
For the disease process Ankylosing Spondylitis, disease causation and cure is not known definitively. There is certain harm when a plaintiff does not receive a definitive diagnosis, monitoring and treatment for years.
The disease ankylosing spondylitis is in the nature of a MINE claim as defined in (Question 3)

Professional negligence in the nature of medical malpractice consists of (1) a duty owed to the plaintiff (2) a breach of that duty by the physician and/or institution (3) a causal connection with plaintiff's harm (4) a direct link between the harm and plaintiff's damages .

Mitzelfelt v. Kamrin 526 Pa. 54, 62, 584 A 2nd 888 891,'90

The Trial Court confused causal connection with the lack of a cure for the disease Ankylosing Spondylitis. By law (3), the disease is in the nature of a MINE claim ; wherein, medical improvement is not indicated. The goal of disease treatment is management and containment of disease progression i.e. in later in life Tay Sachs or Sickle Cell Anemia.

The Court is asked to apply a consistent rule structure; such that, a reasonable person would infer a causal connection between the claimed pain and suffering and the negligence of the practitioner. The law, as described in the Metzelfelt case requires only a causal connection between the physician's negligence and plaintiff's harm.

The Pennsylvania Courts and even some attorneys believe that a disease must be curable in order for a physician's negligence to be compensated under the law.

The decision of the Trial Court and Appellate 3rd Circuit conflicts with the definition of causality by the Appellate 5th Circuit for the disease process Ankylosing Spondylitis.

> "He was diagnosed as suffering from Ankylosing Spondylitis, a chronic progressive and debilitating disease which fuses the spine and causes rigidity of the cervical, thoracic and lumbar vertebrae. "
>
> Smith v. U.S. Railroad Retirement Board 95-60433, 5th Circuit, U.S. Court of Appeals, Politz (Chief Judge), Davis, Emilio Garza
> The Appeals Court set forth the disease and cause.

3. A denial of pain and suffering claims would present a "Manifest Injustice" to incurable disease sufferers because Ankylosing Spondylitis is in the nature of a MINE claim. That is, "Medical Improvement Is Not Indicated". Since improvement is not indicated , the goal of medical practitioners is pain and suffering management and slowing disease progression. A late correct diagnosis would have important implications for alleviating current pain and suffering along with disease progression and considerable intrusion into the normal process of life.
SSA. DI 280 40.001 MINE Sec. 416.99c

A related question is whether or not the plaintiff's presentation to Dr. Mancall on 12-5-96 was so obvious that an ordinary person and not an expert would have recognized the spinal deformity; such that, an expert neurologist needn't be engaged.

Brophy v. Brizuela , 358 Pa. Super, 400, 405, 517 A. 2nd 1293, 1296 , 1986 . The Trial Court ignored testimonial evidence and medical records that were so obvious in physical deformity descriptions that an ordinary person could not possibly mistake the nature of the condition and its underlying characteristics or need for immediate treatment. A. 134

The Court is asked to review whether or not the Amicus Curiae brief submitted to the Appellate 3rd Circuit is admissible for purposes of validating the obvious nature of the plaintiff's condition during the month of 7/1996 a full 5 months prior to the patient's visit to Dr. Mancall MD. The brief sets forth the suspension of the head from the examination table while lying flat, stiffness of the head, shoulder, neck and spine, significant resistance in turning the head either left or right and an impression of ossification.

Appellate 3rd Circuit- Amicus Curiae Brief
Diplomate Charles Deng in Acupuncture

Diplomate Charles Deng testified on 5-4-04 at trial as to his diplomate status and the 7-6-1996 acupuncture encounter wherein he witnessed the musculoskeletal problems foundational to Ankylosing Spondylitis.

4. Discussion of Fed.Register 2-23-1998 P.8990; Writ 2,8

5. The Supreme Court is asked to determine whether the lower courts deliberated the factual basis of the case by reviewing all of the testimony in the expert witness presentation including: c/f A. 15, !6, A 23

- the expert's citation of Dr. Mancall's testimony
- the expert's citation of Dr. John R Waterman's testimony heard by video at trial on 5-5-04 and reproduced in transcript for the Appellate 3rd Circuit

A. 169

- Diplomate Charles Deng's physical presence and testimony at trial during the morning of 5-4-04 together with his Amicus Curiae brief to the Appellate Court 3rd Circuit
  Source: Diplomate Deng Trial Exam on 5-4-04 circa 11AM
  [Appellate Docket 22, 23 on A.26; DC 64 Limine Motion on the testimony of Diplomate Deng as expert appears to have no definitive ruling by the Trial Court on the docket.

The Supreme Court is asked to determine whether or not the Appellate 3rd Circuit erred in excluding the Amicus Curiae brief of Diplomate Deng for purposes of proving obviousness of the disease process in compliance with:
Brophy v. Brizuela and
Smith v. U.S. Retirement Board 95-60433 5th Circuit
Chief : Politz.

The trial testimony of Diplomate Felder MD expert in neurology is a multiple dependant trial examination. A.1-160 The testimony of Diplomate Felder MD multiply depends upon the trial testimony of Dr. John R Waterman MD-Rheumatologist and the physical phenomena witnessed by Diplomate Charles Deng, as well as the testimony of Dr. Elliot L Mancall MD-defendant and Diplomate Felder's interview of the plaintiff.

All of this testimony is in the 3rd Circuit Appellate appendix which would be argued if the Writ is granted. Excerpts are produced on A. 1 to A. 160 in the Writ Appendix created to provide a prelude to the full testimonies of the deponents at trial.

Rulings of the Trial Court:

The Petitioner requests that the Supreme Court consider over-ruling the Trial Court which removed significant evidential matter from the body of testimonial evidence and interfered with the ultimate comprehension of the case.

[Authority-Felder v. Casey]

A.124,125 A delineation of prior medical history describing important spinal range of motion issues brought by the Petitioner to the 12-5-96 encounter with Dr.Mancall. The Trial Court's ruling in favor of defendants concludes that Dr.Mancall did not have the relevant range of motion information available and he had this data. The Trial Court either forgot about this evidence or never entered it despite the fact that the exhibits were approved at trial. A.124-5

A99 -A100 Deposition of Diplomate Deng filed with the Trial Court and read into the Trial Exam of Diplomate Felder authenticates the Petitioner's claim that Dr.Mancall had the requisite range of motion data on hand and did nothing with it. [also see A.100 p. 42 ln. 4 to A.103]

A. 87 Diplomate Felder MD-Neurologist opined: "This is what I reviewed." consisting of the depositions of Dr.Mancall MD, Dr.Waterman MD-Rheumatologist, Diplomate Deng and an interview of the plaintiff. also c/f A135-43

A.103 / p.48 Diplomate Felder's expert testimony confirms that he does not see any quality control review at the Outpatient Clinic of Dr.Mancall in direct violation of the 2-23-98 Fed.Register Requirement for a Compliance Officer in Teaching Hospitals/Facilities. P. 8990

A.146-7 p.10 ln. 7-16 objections should be over-ruled to establish the necessity for early treatment for Ankylosing Spondylitis. see A147 ln.17-19

A154-5 Pg. 42 ln. 4-17 to A155 confirms Anky. Spon.

The Trial Court mis-apprehended the level of knowledge Dr.Mancall had about the case. It believed that the range of motion data was unavailable on 12-5-96; however, Diplomate Deng's testimony contradicts this materially and the patient brought Trial Exh. 124, 125 to the 12-5-96 exam. In effect, the patient did Dr.Mancall's work for him. It is the patient who is monitoring this case and not Dr.Mancall. A.1-14 (Trial Court opinion)

In addition, the Trial Court should have considered that the defendant may have destroyed records; such as the 8/1991 encounter form by Dr.Mancall at the Hahnemann Hospital. The medical student who took the Petitioner's medical history on 12-5-96 is not noted on the face of the TJUH encounter form and this omission is within Dr.Mancall's control. A.115-A117. The patient told Dr.Mancall that he was treating with Imitrex on memos Trial Exh.46-8 on A.120-123. Imitrex is about 9 times as expensive as Fiorinal . The drug which Dr.Mancall claims that he intended to prescribe. Why didn't Dr.Mancall object or call in the patient. A. 116 (Fiorinal noted on the TJUH encounter form)

The Trial Court mis-apprehended the inventory of facts relevant for consideration of the Rule 50 Motion as a Matter of Law. Dr.Felder's Trial Exam A. 83 onward is a multiple dependent Trial Exam. It is dependent upon the testimonies of Diplomate Deng-Acupuncturist, Dr.Waterman MD-Rheumatologist, the plaintiff and Dr.Mancall (defendant). The Trial Court considered only the Trial Exam of Diplomate Felder MD-Neurologist when the related testimonies cited above contained a wealth of facts about the disease process, treatment modalities and pain/suffering issues. Dr.Mancall's conduct is reviewable by the Medical Board of Penn.; the Office of Inspector General HHS and the Joint Commission on Accreditation of Hospitals headed by Commissioner Dr.Richard Frankenstein MD. These avenues of investigation are open to the Petitioner; however, a complaint in these venues would not yield the financial remuneration that a jury could provide.